Supreme Court, U.S.
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No.

IN THE

Supreme Court of the United States

KATHLEEN SEMIEN,

Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a CIGNA COMPANY, and BP LONG TERM DISABILITY (LTD) PLAN,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether the Article III powers of a district court in adjudicating a civil action brought pursuant to ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) are limited to conducting a review proceeding?

LIST OF PARTIES

The parties to this action are all listed in the caption: Kathleen Semien, plaintiff; Life Insurance Company of North America, a CIGNA company, administrator and payor of benefits, defendant; and BP Long Term Disability (LTD) Plan, plan sponsor, defendant.

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OPINION BELOW

The opinion of the United States Court of Appeals for the Seventh Circuit is reported as *Semien v. Life Insurance Co. of North America,* 436 F.3d 805 (7th Cir. 2006)(Reprinted at Appendix 1a-19a). The Court of Appeals affirmed two rulings issued by the United States District Court for the Northern District of Illinois on April 20, 2004 (Appendix 29a-33a) and on October 7, 2004 (Appendix 20a-28a), denying leave to take discovery and granting defendant summary judgment, respectively. Neither of the district court's orders was published.

STATEMENT OF JURISDICTION

This Court's jurisdiction is invoked under 28 U.S.C. §1254(1). The initial subject matter jurisdiction was based on 29 U.S.C. §§ 1132(e)(1) and (f), and 28 U.S.C. § 1331, as this matter arose under the Employee Retirement Income Security Act, a federal law.

The Seventh Circuit's opinion was issued on February 6, 2006. No rehearing was sought.

CONSTITUTIONAL AND STATUTORY PROVISIONS, COURT RULES INVOLVED

Article III, Section 2 of the United States Constitution states in relevant part:

> The Judicial Power shall extend to all Cases, In Law and Equity, arising under this Constitution, the Laws of the United States, and Treaties made…

Title 29, United States Code, Section 1001(b) states:

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries, by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal Courts.

Title 29, United States Code, Section 1132(a) states:

(a) Persons empowered to bring a civil action. A civil action may be brought--

(1) by a participant or beneficiary—

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

Title 29, United States Code, Sections 1132(e)(1) and (f) state:

(e) Jurisdiction.

(1) Except for actions under subsection (a)(1)(B) of this section, the district courts of the United States shall have exclusive jurisdiction of civil actions under this title

brought by the Secretary or by a participant, beneficiary, fiduciary…

(f) Amount in controversy; citizenship of parties. The district courts of the United States shall have jurisdiction, without respect to the amount in controversy or the citizenship of the parties, to grant the relief provided for in subsection (a) of this section in any action.

Federal Rules of Civil Procedure 1 and 2 state in relevant part:

Rule 1. Scope and Purpose of Rules.

These rules govern the procedure in the United States district courts in all suits of a civil nature whether cognizable as cases at law or in equity or in admiralty, with the exceptions stated in Rule 81…

Rule 2. One Form of Action.

There shall be one form of action to be known as "civil action."

Federal Rule of Civil Procedure 26(a)(2)(B) states in relevant part:

Except as otherwise stipulated or directed by the court, this disclosure shall, with respect to a witness who is retained or specially employed to provide expert testimony in the case or whose duties as an employee of the party regularly involve giving expert

testimony, be accompanied by a written report prepared and signed by the witness. The report shall contain a complete statement of all opinions to be expressed and the basis and reasons therefor; the data or other information considered by the witness in forming the opinions; any exhibits to be used as a summary of or support for the opinions; the qualifications of the witness, including a list of all publications authored by the witness within the preceding ten years; the compensation to be paid for the study and testimony; and a listing of any other cases in which the witness has testified as an expert at trial or by deposition within the preceding four years.

Federal Rule of Civil Procedure 26(b)(1) states in relevant part:

Parties may obtain discovery regarding any matter, not privileged that is relevant to the claim or defense of any party…

Federal Rule of Civil Procedure 56(c) states in relevant part:

[Summary judgment] shall be rendered forthwith if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law.

Federal Rule of Civil Procedure 56(e) states in relevant part:

> Supporting and opposing affidavits shall be made on personal knowledge, shall set forth such facts as would be admissible in evidence, and shall show affirmatively that the affiant is competent to testify to the matters stated therein.

Federal Rule of Evidence 802 states:

> Hearsay is not admissible except as provided by these rules or by other rules prescribed by the Supreme Court pursuant to statutory authority or by Act of Congress.

STATEMENT OF THE CASE

1. Employees who have been denied benefits under an employee benefit plan governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.*, are entitled to receive a full and fair review of the benefit denial conducted by the plan fiduciary. 29 U.S.C. § 1133(2) (2006); 29 C.F.R. § 2560.503-1 (2006).

2. If the benefit remains denied following the claim review, the employee may file a civil action to recover benefits due under the plan. 29 U.S.C. § 1132(a)(1)(B) (2006). A stated policy of the ERISA law is to provide ready access to the federal courts. 29 U.S.C. § 1001(b).

3. In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court held that Congress authorized plenary review of benefit denials, although the Court also ruled that ERISA did not prohibit benefit plans from

including plan language that would trigger a deferential standard of review.

4. One question left open by *Firestone,* regardless of the standard of review applied, was whether civil actions authorized by ERISA were to be plenary proceedings governed by the Federal Rules of Civil Procedure or limited solely to a review of a claim record as a court would decide an administrative law claim. This case squarely presents that question.

5. Both the district court and the court of appeals viewed Semien's civil action challenging the termination of her disability benefits as a review proceeding under an administrative law framework. The district court stated, "Since *Perlman [v. Swiss Bank Corp. Comprehensive Disability Protection Plan,* 195 F.3d 975 (7th Cir. 1999], courts in this district have refused to allow discovery on or to supplement the administrative record with material other than what a beneficiary submitted to a plan in support of his or her claim for benefits." Pet.App.33a. The stated rationale for that finding was the court's belief that "deferential review of an administrative decision means review on an administrative record." Pet.App.32a (citing *Perlman,* 195 F.3d at 981-82 (7th Cir. 1999)).

The court of appeals affirmed, stating as a premise that a civil action brought under the ERISA statute is a "review proceeding." Pet.App. 18a. The court derived that conclusion from its finding that "ERISA provides a limited Article III review." (Pet.App. 13a)

6. Kathleen Semien, a 54 year old chemical engineer and environmental specialist who worked for BP Amoco for more than ten years, became disabled in May 2000 due to a liver disorder and degenerative spinal

impairments. Her doctors certified her inability to work due to those medical conditions; and Semien began receiving long-term disability payments under a benefit plan sponsored by her employer. The benefits were both insured and administered by the Life Insurance Company of North America (LINA), a CIGNA company. In addition to insurance benefits, Semien also qualified to receive Social Security disability benefits which signified her inability to engage in "any substantial gainful activity." 42 U.S.C. § 423(d)(1)(A) (2006) (definition of "disabled" under Social Security Act).

Although Semien received treatment for her liver condition, and underwent surgery in January 2002 to fuse the vertebrae in her lower back, by October 2002, Semien's overall condition substantially worsened. Her doctors diagnosed bone spurs and stenosis of the cervical spine which resulted in such severe pain that narcotic medication had to be prescribed. Pet.App. 3a, 22a, 23a. In addition, over the course of her disability, and as a consequence of her chronic illnesses, psychiatric complications developed, leaving Semien so severely depressed that she actively contemplated suicide. Although Semien expressed a strong desire to return to work, when queried by BP Amoco's medical staff, Semien's primary care physician, neurosurgeon, psychiatrist, and psychologist all reported that anticipated restrictions and limitations from pain, fatigue, depression, and stress intolerance would prevent her from sustaining work activity. Pet.App.23a. Consequently, BP Amoco found Semien incapable of returning to work. Pet.App.23a.

Despite LINA's initial determination that Semien qualified for benefits, in October 2002, the insurer terminated Petitioner's payments, contending she was capable of working. When Semien sought a review, LINA

retained Eddie Sassoon, M.D. to review the medical records and furnish an opinion as to whether Semien could work. In a short, conclusory report that ignored the cervical spine impairment as well as the psychiatric issues, Dr. Sassoon corroborated LINA's initial conclusion, although even the Court of Appeals acknowledged, "it was unclear...exactly what information he reviewed" (Pet.App. 5a). LINA also retained a psychiatrist, Jack Greener, M.D., to review Semien's medical records; and without considering her physical impairments, he found her capable of performing a sedentary occupation. Pet.App. 5a.

Based on its consultants' reports, and in the absence of a medical examination or even direct consultation with Semien's physicians, LINA upheld its determination. Semien then filed suit pursuant to 29 U.S.C. § 1132(a)(1)(B) (2006) seeking restoration of her benefits. Because she had no opportunity during the pre-suit appeal to cross-examine LINA's consultants, Petitioner requested limited discovery to investigate any financial bias and other prejudicial relationships that might exist between LINA and the consultants it retained. LINA refused to permit the discovery, though; and the district court denied Semien's request to compel discovery on the ground that ERISA proceedings proscribe discovery. Pet.App. 29a-33a.

Subsequently, on October 7, 2004, despite the court's acknowledgement that the evidence establishing Semien's disability could have supported a judgment in her favor (Pet.App.27a), the court ignored the conflict in the evidence and granted summary judgment to the defendants. Pet.App.20a-28a. Without giving the Petitioner the opportunity to investigate bias or other potential flaws in the claims process, the court credited the insurer's consultants' reports as substantial evidence sufficient to uphold the benefit termination under an arbitrary and capricious

standard of court review. Pet.App. 20a-28a. Petitioner filed a timely notice of appeal on October 14, 2004.

The Seventh Circuit affirmed the district court's ruling in all respects in a decision issued on February 6, 2006. Pet.App. 1a-19a. While accepting that Semien's evidence provided "rational" support for a contrary conclusion, the court nonetheless found no reason to allow Petitioner any means to present a challenge to the reports prepared by LINA's consultants. Pet.App. 9a. As its rationale, the Court of Appeals applied an administrative law paradigm, deeming the adjudication of ERISA civil actions as "review proceedings" and expressing a concern that "Congress has not provided Article III courts with the statutory authority, nor the judicial resources, to engage in a full review of the motivations behind every plan administrator's discretionary decisions." Pet.App.18a.

Both the paradigm applied, and the ruling of the Seventh Circuit, conflict with the language of the ERISA statute, its legislative history, and with rulings issued by this Court and by the First, Second, Third, Fifth, Sixth, Eighth, Ninth and Eleventh Circuit Courts of Appeals.

REASONS FOR ALLOWANCE OF THE WRIT

I. *The Semien Ruling Conflicts With the ERISA Statute, Prior Rulings of the Supreme Court, and Rulings Issued By Other Courts of Appeals*

A. The *Semien* Ruling Conflicts with the ERISA Statute's Creation of Civil Actions as Well as This Court's Recognition that Civil Actions are Not "Review Proceedings" Absent Explicit Statutory Direction

1. The Language of the ERISA Statute Precludes Characterization of ERISA Civil Actions As Review Proceedings

Civil actions authorized by § 502 of the Employee Retirement Income Security Act are not "review proceedings" of a claim record as the Seventh Circuit ruled. Pet.App. 18a. Congress' authorization of a "civil action...to recover benefits due ... under the terms of [a] plan" (29 U.S.C. § 1132(a)(1)(B) (2006)) entitles plan participants to a plenary court proceeding rather than a claim record review under the principles enunciated in *Chandler v. Roudebush,* 425 U.S. 840 (1976).

In *Chandler,* the identical issue arose with respect to employees bringing civil actions to redress discrimination in federal employment pursuant to § 717(c) of the Civil Rights Act, 42 U.S.C. §2000e *et seq.*. While some lower courts had ruled that such actions involved a review of the record made at prior administrative proceedings, this Court overruled those decisions and held that federal employees were entitled to discovery and a trial rather than a review proceeding, explaining: "Nothing in the legislative history indicates that the federal-sector "civil action" was to have this chameleon-like character, providing fragmentary de novo consideration

of discrimination claims where "appropriate," ibid., and otherwise providing record review." 425 U.S. at 861. The Court added,

> In most instances, of course, where Congress intends review to be confined to the administrative record, it so indicates, either expressly or by use of a term like "substantial evidence," which has "become a term of art to describe the basis on which an administrative record is to be judged by a reviewing court." Ibid. E. g., 5 U.S.C. § 706 (scope-of-review provision of Administrative Procedure Act); 12 U.S.C. § 1848 (scope-of-review provision applicable to certain orders of the Board of Governors of the Federal Reserve System); 15 U.S.C. § 21 (c) (scope-of-review provision applicable to certain orders of the Interstate Commerce Commission, the Federal Communications Commission, the Civil Aeronautics Board, the Federal Reserve Board, and the Federal Trade Commission); 21 U.S.C. § 371 (f)(3) (scope-of-review provision applicable to certain orders of the Secretary of Health, Education, and Welfare).

425 U.S. at 862 n.37.

Applying *Chandler's* analysis, it is evident that nowhere in the statute itself or in the legislative history of the ERISA law is the term "substantial evidence" used; nor is there any support for a conclusion that Congress intended ERISA civil actions would be review proceedings.

2. The Seventh Circuit's Conclusion that a District Court's Article III Powers Are Limited Under ERISA Is Contrary to ERISA's Legislative History

The previous argument is reinforced by ERISA's legislative history which is completely contrary to the Seventh Circuit's conclusion that the federal courts' Article III powers are limited in deciding ERISA benefit disputes. While the *Semien* opinion cites a purported Congressional intent that ERISA provide "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously," (Pet.App. 18a), the citation for that comment can be traced to Senate Report 93-383 accompanying S.1179, a predecessor to the bill that eventually became the ERISA law. The draft bill afforded pension claimants the opportunity to pursue a grievance or arbitration proceeding before the Secretary of Labor; and the report refers to such a proceeding as providing "the opportunity to resolve any controversy over [ ] retirement benefits under qualified plans in an inexpensive and expeditious manner...Accordingly, the committee has decided to provide that controversies as to retirement benefits are to be heard by the Department of Labor." S.Rep. 93-383, reprinted in 1974 U.S. Code Cong. & Admin. News 5000.

That provision was dropped from the final bill, though; and nowhere in the ERISA statute is there any provision limiting the manner in which the courts are to resolve civil actions brought by welfare plan participants pursuant to 29 U.S.C. §1132(a). On the contrary, the Conference Report explained that ERISA civil actions "are to be regarded as arising under the laws of the United States in similar fashion to those brought under section 301 of the Labor-Management Relations Act of 1947." H.R. Conf. Rep.

93-1280, 93d Cong., 2d Sess. 327 (1974). According to *Textile Workers Union v. Lincoln Mills,* 353 U.S. 448, 456 (1957), Section 301 (29 U.S.C. §185) requires the federal courts to "fashion from the policy of our national labor laws" a federal common law governing the interpretation of collective bargaining agreements which includes plenary proceedings that even encompass trials before juries. *See, Chauffeurs, Teamsters & Helpers, Local No. 391 v. Terry,* 494 U.S. 558 (1990).

The statutory history of 29 U.S.C. § 1133 further supports a conclusion that the absence of an evidentiary hearing or even an arbitral forum prior to suit mandates plenary procedures. According to the House Conference Report, § 1133 was included as a compromise between the original House Bill, which had no such provision and the Senate Bill, which provided for review and arbitration of benefit disputes. H.R.Rep.No.93-1280, 93d Cong., 2d Sess., reprinted in 1974 U.S.Code Cong. & Ad.News 5038, 5108. Further, the absence of an administrative hearing or discovery proceedings from the claim regulations applicable to 29 U.S.C. § 1133, 29 C.F.R. §2560.503-1, underscores the need for plenary proceedings for plan participants who initiate civil actions to redress benefit claim denials.

In contrast to the benefit claim regulations, other ERISA regulations create an administrative process for adjudicating prohibited transaction penalties, with discovery procedures and an explicit statement that ensuing civil actions are review proceedings. *Compare* 29 C.F.R. §§ 2560.502i-1, 2570.7, and 2570.11. In the absence of any comparable process for claim appeals, though, there is no basis for adjudicating ERISA benefit suits as review proceedings; and the plenary procedures afforded by the Federal Rules of Civil Procedure are to be accorded plan participants seeking relief under 29 U.S.C. §1132(a)(1)(B).

Although the Court has never ruled on this precise issue, it has acknowledged Congress' intent to provide plenary proceedings under the ERISA law rather than having the court review a claim record that amounts to little more than unsworn hearsay evidence. In *Massachusetts Mutual Life Insur.Co. v. Russell,* 473 U.S. 134, 144 (1985), the Court explained that the statutory provision authorizing a civil action under the ERISA law, 29 U.S.C. § 1132(a)(1)(B), "enables a claimant to bring a civil action to have the merits of his application determined, just as he may bring an action to challenge an outright denial of benefits." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 110 (1989) further dispels any basis for interpreting the ERISA statute in a manner that prohibits plenary proceedings: "Unlike the LMRA[1] [29 U.S.C. § 186(c)(2) 2006], ERISA explicitly authorizes suits against fiduciaries and plan administrators to remedy statutory violations, including breaches of fiduciary duty and lack of compliance with benefit plans. 29 U.S.C. §§ 1132(a), 1132(f)."

Moreover, the Court has cautioned against deeming pre-litigation claim appeals a substitute for plenary proceedings. In *Rush Prudential HMO, Inc. v. Moran,* 536 U.S. 355, 385 (2002), the Court found:

> [ERISA] requires plans to afford a beneficiary some mechanism for internal review of a

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[1] Cases such as *Beam v. Intl. Org. of Masters, Mates and Pilots,* 511 F.2d 975, 980 (2d Cir. 1975) had characterized LMRA proceedings as seeking review of Trustees determinations after pointing out that "review in this case is not the examination of a dispute between an insurance company with a boilerplate contract on one hand and a consumer on the other." In contrast, that is exactly what occurred here; and unlike benefit trusts established under the LMRA where both management and the employees appoint trustees, the decisionmaker here was an insurance company, further supporting this Court's distinction between claims under the LMRA and ERISA claims.

> benefit denial, 29 U.S.C. § 1133(2), and provides a right to a subsequent judicial forum for a claim to recover benefits, § 1132(a)(1)(B). Whatever the standards for reviewing benefit denials may be, they cannot conflict with anything in the text of the statute, which we have read to require a uniform judicial regime of categories of relief and standards of primary conduct, *not a uniformly lenient regime of reviewing benefit determinations.* (citation omitted)(emphasis added).

Thus, while expeditious and inexpensive litigation is the desired goal of all civil procedure (*See,* Fed.R.Civ.P. 1), *Semien's* reliance on a supposed Congressional intent to curtail the civil procedure accorded ERISA proceedings deviates from the statute. Neither the statutory language nor ERISA's legislative history provides support for the Seventh Circuit's conclusion that a district court's Article III powers are limited under ERISA. Pet.App. 18a. Congress created a civil action for plan participants with the intent that the law not afford "less protection to employees and their beneficiaries than they enjoyed before ERISA was enacted." *Firestone Tire & Rubber Co. v. Bruch,* 489 U.S. 101, 114 (1989).[2]

Before ERISA, federal courts applied contract law to resolve employee benefits disputes. See Brief of Solicitor General in *Firestone*, 1987 U.S. Briefs 1054, at 5 n.7. Unquestionably, the dispute here arose over an insurance contract, and would have been resolved through plenary court proceedings notwithstanding the ERISA law. *See, e.g.,*

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[2] *Firestone* also dismissed an argument that considerations relating to the cost of litigation are grounds for limiting court review (489 U.S. at 115), further undermining the Seventh Circuit's rationale.

Cox v. Washington Natl. Insur.Co., 520 S.W.2d 76 (Ct.App.Mo. 1974)(employer sponsored disability benefit claim accorded plenary civil procedure); *Antram v. Stuyvesant Life Insur.Co.*, 287 So.2d 837 (Ala. 1973)(same).

Moreover, even under the common law of trusts, which underpins much of the ERISA statute according to *Firestone*, plenary proceedings were the norm prior to ERISA. *See, e.g., Barnett v. Ross,* 333 Pa. 510, 3 A.2d 923, 925 (Pa. 1939) (in an action for breach of implied trust by fiduciary, plaintiff beneficiary may seek a bill of discovery in equity to support a claim of existence of trust and misconduct of alleged trustee); *Phelps Dodge Corp. v. Brown,* 112 Ariz. 179, 540 P.2d 651 (1975)(jury trial conducted); *Matthews v. Swift & Co.*, 465 F.2d 814 (5th Cir. 1972)(plenary bench trial of pension and disability claim despite arbitrary and capricious standard of review).

Although this Court ruled in *Firestone* that federal courts are to determine employee benefit claims brought under the ERISA law pursuant to a plenary standard of review unless the plan stipulates for a more deferential standard, neither that ruling, nor any other Supreme Court decision limits the scope of civil procedures available under ERISA. What the *Semien* case appears to have misperceived is a distinction between a plenary proceeding and a *de novo* standard of court review. Even under an arbitrary and capricious standard of review, such as the one applied by the district court and by the Court of Appeals in this case, a court must examine in the first instance whether the decision-maker "entirely failed to consider an important aspect of the problem [or] offered an explanation for its decision that runs counter to the evidence." *Motor Vehicle Mfr. Ass'n v. State Farm Mutual Auto. Ins. Co.*, 463 U.S. 29, 43 (1983). Likewise, in *McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161, 172-173 (6th Cir. 2003), the Sixth Circuit

explained that when a court reviews an ERISA plan administrator's decision, the determination of whether a plan administrator's decision is arbitrary and capricious

> inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issues. Otherwise, courts would be rendered to nothing more than rubber stamps for any plan administrator's decision as long as the plan was able to find a single piece of evidence-no matter how obscure or untrustworthy-to support a denial of a claim for ERISA benefits. (citation omitted)

Consequently, a showing of whether a plan administrator's determination is arbitrary and capricious requires that the claimant be afforded the same tools as any other litigant bringing a civil action in the district court, contrary to the Seventh Circuit's deprivation of the discovery Petitioner sought. Rule 1 of the Federal Rules of Civil Procedure mandates applicability of the Rules to all civil actions other than those enumerated in Rule 81, with no exception made for ERISA cases. Indeed, in *New Hampshire Fire Ins.Co. v. Scanlon,* 362 U.S. 404, 406 (1960), this Court ruled that even in tax levies, plenary procedures are required. The Court explained:

> Summary trial of controversies over property and property rights is the exception in our method of administering justice. Supplementing the constitutional, statutory, and common-law requirements for the adjudication of cases or controversies, the Federal Rules of Civil Procedure provide the normal course for beginning, conducting, and

> determining controversies. Rule 1 directs that the Civil Rules shall govern all suits of a civil nature, with certain exceptions stated in Rule 81 none of which is relevant here. Rule 2 directs that "There shall be one form of action to be known as 'civil action.'"

The Seventh Circuit's ruling, which exempts ERISA cases from the Federal Rules of Civil Procedure, is inconsistent with these principles.

B. The *Semien* Ruling Conflicts with Rulings Issued by Other Circuits

The Seventh Circuit's treatment of ERISA cases is also directly contrary to rulings issued by virtually every other Circuit. The Seventh Circuit has disregarded this Court's mandatory injunction in *Firestone* that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, "that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" 489 U.S. at 115 (citing Restatement (Second) of Trusts § 187, Comment d.)(emphasis added). Applying that directive, in *Calvert v. Firstar Finance, Inc.*, 409 F.3d 286, 292 (6th Cir. 2005), the Sixth Circuit expressed concern about consultants, such as the doctors identified in the *Semien* ruling, who are hired by insurers to review claims: "As the plan administrator, Liberty had a clear incentive to contract with individuals who were inclined to find in its favor that Calvert was not entitled to continued LTD benefits."[3] Consequently, the Sixth Circuit

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[3] This Court, too, expressed concern in *Black & Decker Disability Plan v. Nord,* 538 U.S. 822, 832 (2003) that "physicians repeatedly retained by benefits plans may have an incentive to make a finding of 'not disabled' in order to save their employers[']' money and preserve their own consulting arrangements." (citation omitted).

admonished that discovery would provide "a better feel for the weight to accord this conflict of interest." 409 F.3d at 293 n.2.

Similarly, the First Circuit allows discovery relating to corruption in the claim review process. *Liston v. Unum Corp. Officer Severance Plan,* 330 F.3d 19 (1st Cir. 2003). Conflict of interest discovery is also permitted in the Second Circuit (*Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163 (2d Cir. 2001)); the Third Circuit (*Pinto v. Reliance Standard Life Insur.Co.*, 214 F.3d 377 (3d Cir. 2000)); the Fifth Circuit (*Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346, 356 (5th Cir. 2004) ("There is no practical way for the extent of the administrator's conflict of interest to be determined without the arbitrator going beyond the record of the administrator.")); the Eighth Circuit (*Farley v. Arkansas Blue Cross & Blue Shield,* 147 F.3d 774 (8th Cir. 1998)); the Ninth Circuit (*Tremain v. Bell Industries,* 196 F.3d 970 (9th Cir. 1999)); and the Eleventh Circuit (*Moon v. American Home Assur.Co.*, 888 F.2d 86 (11th Cir. 1989)).

However, the Seventh Circuit stands alone in restricting a claimant's ability to establish the arbitrariness of a plan administrator's determination. While the *Semien* ruling does not altogether disallow discovery, its approach of granting discovery in ERISA cases only if the insured can first produce credible evidence justifying discovery (Pet.App. 17a) applies circular reasoning in constraining discovery that would otherwise routinely fall within the scope of discovery permitted under Fed.R.Civ.P. 26(b)(1) and would involve the type of expert witness disclosure mandated by Rule 26(a)(2)(B) in order to reveal potential bias. A plan participant has no means of proving bias or establishing that a plan administrator's decision was arbitrary and capricious if denied the tools necessary to investigate the underlying basis of the determination.

The fruits of discovery in ERISA cases, when taken, have provided compelling evidence of arbitrary and capricious conduct and/or bias. For example, in *Bedrick v. Travelers Insur.Co.*, 93 F.3d 149 (4th Cir. 1996), discovery revealed the consultants whose opinions were relied on by a medical benefit plan in denying therapy for a child suffering from cerebral palsy lacked adequate qualifications. *Miller v. United Welfare Fund*, 72 F.3d 1066, 1072 (2d Cir. 1995) also relied on deposition testimony of the plan's administrator to find that none of the decisionmakers involved in denying a claimant's request for benefits understood the medical information in the claimant's file, thus leading to a conclusion that the benefit determination was arbitrary and capricious. Thus, as *Nagele v. Electronic Data Sys. Corp.*, 193 F.R.D. 94, 104 (W.D.N.Y. 2000) observed,

> as the arbitrary and capricious standard requires courts to scrutinize, although deferentially, decisions by plan fiduciaries for lack of reasonableness, including the absence of substantial evidence, such deficiencies in the administrative review function can be significantly illuminated through the reasonable exercise of standard discovery devices available in federal civil practice.

193 F.R.D. at 104.

Therefore, because the arbitrary and capricious standard of review is made more meaningful, rather than diminished, by allowing discovery, the disallowance of discovery in this case was an aberration and a departure from rulings issued by other Courts of Appeals.

II. *The Semien Ruling Creates A Quasi-Administrative Law Lacking the Protections of Administrative Claim Determinations*

Contrary to the framework established by the Federal Rules of Civil Procedure for the adjudication of civil actions, the *Semien* decision transforms the ERISA law into a quasi-administrative law devoid of the protections that comprise a fair administrative hearing. By simply reviewing the claim record rather than allowing for plenary procedures, the Seventh Circuit deprived Semien of rights she would have possessed had this case involved an administrative law proceeding, such as a Social Security disability claim.

The Court of Appeals' conclusion that the reviewing doctors' opinions "demonstrate a thorough consideration of the available information" (Pet. App. 12a), when the reports were controverted and no cross-examination was allowed, is in conflict with *Richardson v. Perales,* 402 U.S. 389, 402-406 (1971). *Perales,* which involved Social Security disability benefits, ruled that an examining physician's report may constitute substantial evidence in an *administrative proceeding* only when nine separately enumerated assurances of trustworthiness were met. None of those protections, which include the fact that the medical report was prepared by a percipient witness who had personally conducted a clinical, scientifically valid medical examination, and the claimant retained the opportunity to cross-examine the author of the report, were present in this case. Nor was Semien given any opportunity to have her claim adjudicated prior to suit by a body possessing the same neutrality and objectivity as an administrative agency, or even by an arbitrator.

Indeed, ERISA benefit adjudications performed by insurance companies are fundamentally different from Social Security disability claims because "the agency operates

essentially, and is intended so to do, as an adjudicator and not as an advocate or adversary." *Perales,* 402 U.S. at 403. Although the *Semien* ruling expressed an opinion that it had no cause to suspect bias by the insurer (Pet.App. 16a), the Respondent faces a perpetual conflict between its fiduciary duty to its shareholders and its fiduciary duty to plan participants mandated by § 404 of the ERISA statute (29 U.S.C. § 1104(a)(1) (2006)). Therefore, one of the major justifications for giving deference to an administrative agency, neutrality, is absent here. Yet the implication of what the Court of Appeals ruled in *Semien* means that claimants in ERISA benefit disputes are "effectively precluded as a matter of law any procedural challenge to an ERISA plan administrator's decisions, thereby giving those decisions a uniquely privileged position in the entire field of administrative or quasiadministrative law." *Perlman v. Swiss Bank Corp.,* 195 F.3d 975, 983 (7th Cir. 1999)(Wood, J., dissenting).

Semien's application of an administrative law paradigm of judicial review has also been rejected by several Courts of Appeals including other panels within the Seventh Circuit. In *Herzberger v. Standard Insur.Co.,* 205 F.3d 327 (7th Cir. 2001), the court reiterated the point expressed earlier in *Van Boxel v. Journal Co. Employees Pension Trust,* 836 F.2d 1048, 1050 (7th Cir. 1987) that "Pension fund trusts are not administrative agencies," nor are they "policy makers; they are interpreters of contractual entitlements." *Herzberger* added that the courts have drawn a mistaken analogy between ERISA-governed disability benefit claims and Social Security claims by pointing out that the "Social Security Administration is a public agency that denies benefits only after giving the applicant an opportunity for a full adjudicative hearing before a judicial officer, the administrative law judge." 205 F.3d at 332. The Eleventh Circuit has also issued a stern caution against

importing "administrative agency concepts into the review of ERISA fiduciary decisions." *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1564 n. 7 (quoting *Van Boxel*) (11th Cir. 1990). Yet despite these warnings, the *Semien* ruling improperly relies on an administrative law framework.

This Court has also questioned the evidentiary weight to be given to medical reports used in ERISA claims. *Black & Decker Disability Plan v. Nord,* 538 U.S. 822 (2003) ruled that while an ERISA plan administrator need not give special deference to the opinions of treating doctors in disability benefit disputes, plan administrators were still required to base their findings on "reliable evidence." 538 U.S. at 834. In *Nord,* the treating physician's opinion was controverted by an independent examining doctor. However, in this case, the consultants on which the plan administrator relied had never examined the claimant, and as the Seventh Circuit acknowledged, it was not even clear what evidence the consultants had reviewed. Pet.App. 12a. Thus, for a court to credit those consultants' findings over the treating doctors' reports, without allowing any inquiry into the reliability of the findings made, is contrary both to *Nord* and *Perales.* In order to assess whether the plan administrator's evidence is "reliable," as *Nord* requires, claimants must have the opportunity to conduct appropriate discovery and be accorded a plenary hearing.

In sum, the Petitioner was denied the protection of Rule 56 of the Federal Rules of Civil Procedure and Federal Rule of Evidence 802's prohibition against hearsay evidence. Summary judgment may only be entered when based on admissible evidence according to Fed.R.Civ.P. 56(e). Because there was no guarantee that the evidence on which the plan denial was based was admissible or even "reliable," both *Nord* and *Perales* reveal the flaw in the regime the

Seventh Circuit has created for the adjudication of ERISA disputes.

III. *The Semien Ruling Disregards The Societal Importance of Employee Benefits*

The decision issued by the Court of Appeals finding that "ERISA provides a limited Article III review" (Pet.App. 13a) disregards the societal importance of employee benefits. Surely, the preamble to the ERISA statute (29 U.S.C. § 1001(b) (2006)), which speaks of protecting plan participants and assuring adequate remedies and access to federal court, makes it clear Congress intended that protection of the disabled deserves the full attention of Article III courts. Insurance company statistics show that "one out of five 35-year-olds will experience a disability that lasts three months or more before age 65." www.massmutual.com/mmfg/service/di/whygetdi.html. Working women are even more adversely affected and are deemed "three times more likely than men to miss work due to a disability related illness." www.efmoody.com/insurance/disabilitystatistics.html. According to the Social Security Administration, more than 2.1 million individuals applied for Social Security disability insurance in 2005, a 4.39% increase over the prior year. www.ssa.gov/OACT/STATS/dibStat.html.

Other statistics reveal that approximately 50 million Americans who work in the private sector participate in retirement plans regulated by ERISA. Life, health and disability plans cover even more people. J. Wooten, *The Employee Retirement Income Security Act of 1974 – A Political History* 2 (U.Cal. Press 2005). Consequently, "decisions whether and how to ensure that disability does not lead to poverty are obviously of great societal importance." *Radford Trust v. Unum Life Insur.Co. of America,* 321 F.Supp.2d 226, 240 (D.Mass. 2004). The media has also

begun focusing on ERISA and the need for more penetrating judicial review. The story of how a law intended to protect employee benefits has been used to shield disability insurers was told in the *Los Angeles Times* by reporter Peter G. Gosselin in his article, "The Safety Net She Believed in Was Pulled Away When She Fell." (August 21, 2005). The *Wall Street Journal* similarly reported on December 3, 2005 that the ERISA statute "has evolved into one that covers far broader territory and can have an unanticipated effect, tilting the playing field in favor of employers and serving as a legal shield for them." Ellen Schultz, "A Hobbled Star Battles the NFL." Even the authoritative medical journals have concluded that "ERISA plans have a financial incentive to deny care...without liability, there is nothing in the law to counterbalance the financial incentive to deny care." Mariner, "What Recourse? – Liability for Managed-Care Decisions and the Employee Retirement Income Security Act," *New England Journal of Medicine* 343: 592, 595 (August 24, 2000).

Accordingly, the issues raised in this petition merit review. The importance of employee benefits claims and consistency in treatment of civil actions authorized by Congress mandates review by this Court. The absence of penalties and damages in the ERISA law means that meaningful court review is the only way to hold ERISA plan administrators accountable. The Seventh Circuit's ruling is an aberration, inconsistent with the ERISA statute, its legislative history, and rulings issued both by this Court and by the other Circuits.

CONCLUSION

For all of these reasons, Petitioner, Kathleen Semien, prays that this Court issue a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit.

Respectfully submitted,

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IN THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

KATHLEEN SEMIEN, Plaintiff-Appellant,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a CIGNA COMPANY, and BP LONG TERM DISABILITY (LTD) PLAN, Defendants-Appellees.

No. 04-3664

436 F.3d 805

February 6, 2006, Decided

COUNSEL: For KATHLEEN SEMIEN, Plaintiff - Appellant: Mark D. DeBofsky, DALEY, DEBOFSKY & BRYANT, Chicago, IL USA.

For LIFE INSURANCE COMPANY OF NORTH AMERICA, A Cigna Company, BP LONG TERM DISABILITY PLAN, Defendants - Appellees: Stephen R. Swofford, Christine Olson McTigue, HINSHAW & CULBERTSON, Chicago, IL USA.

Before FLAUM, Chief Judge, and BAUER and EVANS, Circuit Judges.

[*807] FLAUM, *Chief Judge*. The defendant, Life Insurance Company of North America ("LINA"), terminated the payment of long term disability benefits to the plaintiff, Kathleen Semien. In response, Semien filed suit against her benefit plan, BP Long Term Disability Plan, and LINA seeking an order compelling LINA to continue payment of her disability benefits.

Additionally, Semien sought to compel discovery in order to gather evidence about the relationship between the physicians LINA consulted and the insurer. The district court denied Semien's motion to compel discovery and granted summary judgment in favor of the defendants. Semien appeals the district court's denial of her discovery requests as well as the district court's grant of summary judgment to LINA.

For the following reasons, we now affirm the judgment of the district court.

I. Background

Kathleen Semien is a 54-year old woman who began working for BP-Amoco in February 1989 as an environmental remediation manager. On May 15, 2000, when Semien left BP-Amoco, she was employed as a chemical engineer. Her occupation required significant travel, concentration, teamwork, and quick reactions. Upon leaving her job, Semien filed a disability claim with BP's Long Term Disability Plan.

BP established its Consolidated Welfare Benefit Plan ("Plan") to provide long-term disability benefits to eligible employees. BP adopted a Plan Governance Amendment on January 31, 2000. The Amendment defined an "Administrative Named Fiduciary" as any entity that entered into an Administrative Services Agreement with the Plan Administrator. Administrative Named Fiduciaries were granted the authority to "Exercise such discretion as may be

required to construe and apply the provisions of the Plan, subject only to the terms and conditions of the Plan." On April 1, 2000, LINA entered into an Administrative Services Agreement with Semien's employer covering long-term disability [*808] claims arising out of the Plan. As part of this Administrative Services Agreement, LINA would screen benefits and determine whether claims were payable under the Plan. In addition, LINA insured the benefits of employees under the Plan.

Semien asserts that she suffers from a variety of medical conditions: back pain, a herniated lumbar disk, bone spurs in her neck, carpal tunnel syndrome, other problems in her joints and extremities, fibromyalgia (a disease with no known causes or cure, but with symptoms including chronic pain "all over," fatigue, disturbed sleep, and other problems), and past sickness as a result of Hepatitis C. In addition to her alleged physical ailments, Semien also claims to suffer from chronic depression and mental confusion. She has been described as having suicidal thoughts and "masochistic, schizoid, and narcissistic features." Semien is currently taking several medications for pain, sleeping problems, and depressive disorders.

LINA received Semien's initial claim on September 15, 2000. This initial claim was approved on November 15, 2000. The bases for LINA's approval of benefits were side effects from Hepatitis C, medication, fatigue, and pain. In its initial approval, LINA stated its intent to monitor Semien's condition and reserved the right to request additional records. To receive benefits for the first 24 months of disability insurance, Semien only needed to show that she could not perform her "Regular Occupation or a Qualified Alternative" at BP. After the initial 24-month period, a more stringent standard applied.

During the two-year initial disability period, Semien submitted many medical records to LINA. Semien's

physicians also completed assessments on her behalf. Some of these assessments indicated that Semien was capable of performing moderate work, but cautioned that her abilities were limited. Semien received fusion surgery on her back in January 2002.

On May 8, 2002, LINA sent Semien a letter stating that she would remain eligible for benefits only if illness prevented her from performing any qualified work or earning 80% or more of pre-disability earnings. Additionally, during this time period, Semien's disability payments were reduced in part to offset the money she received from social security disability payments.

In a letter dated November 22, 2002, LINA notified Semien that "the information we have on file to date does not establish that you meet the Policy definition of Disabled. Accordingly, [long term disability] benefits are not payable beyond November 14, 2002, under this policy." LINA further explained, "Your file was . . . reviewed by a Nurse Care Manager and a Behavior Care Specialist. It was noted that the medical documentation does not support your inability to perform your occupation as an Environmental Business Manager[.] . . . Accordingly no additional benefits are payable under the policy."

The language of the long-term disability plan states:

> After Disability Benefits have been payable for 24 months, the Employee is considered Disabled if, solely because of Injury or Sickness, he or she is either:
>
> > 1. unable to perform all the material duties of any occupation for which he or she is, or may reasonably

> become, qualified based on education, training or experience; or
>
> 2. unable to earn 80% or more of his or her Indexed Covered Earnings.

On March 25, 2003, Semien appealed LINA's termination decision. She submitted a great deal of medical evidence to support her appeal. LINA hired an independent psychiatric consultant, Dr. Jack [*809] Greener, to review the medical history in Semien's file. Dr. Greener did not personally examine Semien.

Dr. Greener's report concluded that Semien's depression was severe enough to prevent her from functioning in a work setting from January 24, 2003, to February 21, 2003. He stated that, "The psychiatric documentation demonstrates a degree of depression of moderate severity and then of severe degree, which would preclude the client from performing her regular job according to the job description supplied." In an addendum to his original report, Dr. Greener wrote, "After careful review it is evident that the client is capable of performing a sedentary to light job, which does not require irregular and unplanned hours, evening meetings, responses 24 hours a day, [and] emergency responses, which would require immediate attention and travel."

Dr. Eddie Sassoon, a physician retained by LINA, also concluded from a review of Semien's medical records that she was capable of performing a sedentary or light duty occupation. Semien contends that Dr. Sassoon did not assess her psychiatric impairments or consider records from Dr. Liu or Dr. Nagle. It is unclear from Dr. Sassoon's evaluation, which consisted of only two pages, exactly what information he reviewed. Dr. Sassoon stated that "the report was completed in the interest of time constraints, based on the documentation provided, which was extensive in nature."

Lynne Lonberg, an independent senior rehabilitation counselor and vocational expert retained by LINA, conducted a Transferable Skills Analysis based on the physicians' appraisals. In this analysis, Lonberg listed several "potential occupations Ms. Semien could perform within her skills, education, physical/mental abilities and wage requirement [of 80% of Indexed Covered Earnings.]" Potential suitable occupations included employment as a chemical engineer, chemical research engineer, or absorption and adsorption engineer.

In a letter dated June 27, 2003, LINA affirmed its determination that Semien was not disabled under the terms of the plan and therefore did not qualify for benefits after November 14, 2002. On July 11, 2003, Semien filed suit under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), seeking an order forcing LINA to award her disability benefits under the Plan.

During the course of this litigation, LINA refused to comply with five discovery requests: one interrogatory and four document production requests related to the relationship between LINA and the physicians consulted. Semien filed a motion to compel discovery with the district court. This motion to compel discovery was denied in an opinion dated April 21, 2004.

On October 7, 2004, the district court entered summary judgment for LINA, holding that LINA's decision on Semien's claim for benefits was not arbitrary and capricious. The district court also added in a footnote that "the denial of benefits would survive even if we applied the de novo standard."

II. Discussion

We review a district court's grant of summary judgment using a de novo standard. *See, e.g., Grun v. Pneumo Abex Corp.*, 163 F.3d 411, 419 (7th Cir. 1998). "That is, we

review 'without deference for the view of the district judge and hence almost as if the motion had been made to us directly.'" *Id.* (quoting *Tobey v. Extel/JWP, Inc.*, 985 F.2d 330, 332 (7th Cir. 1993)).

[*810] **A. Appropriate Standard of Review Under ERISA**

The initial question in this appeal is whether the district court used the proper standard of review when evaluating the plan administrator's denial of benefits. The standard of judicial review in civil actions under 29 U.S.C. § 1132(a)(1)(B) depends upon the discretion granted to the plan administrator in the plan documents. *See Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989) ("Consistent with established principles of trust law, we hold that a denial of benefits challenged under § 1132(a)(1)(B) is to be reviewed under a *de novo* standard unless the benefit plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to construe the terms of the plan.").

"The presumption of plenary review is not rebutted by the plan's stating merely that benefits will be paid only if the plan administrator determines they are due, or only if the applicant submits satisfactory proof of his entitlement to them." *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 331 (7th Cir. 2000). In order to lower the level of judicial review from de novo to arbitrary and capricious, "the plan should clearly and unequivocally state that it grants discretionary authority to the administrator." *Perugini-Christen v. Homestead Mortgage Co.*, 287 F.3d 624, 626 (7th Cir. 2002).

The district court found that the BP Long Term Disability Plan granted discretionary authority to LINA. Therefore, the plan administrator's "decision had to be

examined under the 'arbitrary and capricious' standard of review." The district court provided two bases for its decision. In an April 21, 2004, opinion denying Semien's motion to compel discovery, the district court cited the Plan's Employee Benefits Handbook for authority to use an arbitrary and capricious standard of review. In the October 7, 2004, opinion granting summary judgment, the district court cited the BP Long-Term Disability Plan and a subsequent Administrative Services Agreement between BP and LINA as mandating an arbitrary and capricious standard of review.

Semien challenges the validity of the Employee Benefits Handbook. She claims that because the handbook was not published as part of the plan until after the initial denial of benefits, it may not be considered in evaluating her claim. *See* Hackett v. Xerox Corp. 315, F.3d 771, 774 (7th Cir. 2003); *but see Daill v. Sheet Metal Workers' Local 73 Pension Fund*, 100 F.3d 62 (7th Cir. 1996). We need not reach the question of the handbook's validity. Regardless of whether the handbook was properly considered, the BP Long-Term Disability Plan, coupled with the Administrative Services Agreement between BP and LINA, established LINA's authority and requires that decisions by the plan administrator be reviewed under an arbitrary and capricious standard.

The BP Long-Term Disability Plan explicitly provides for arbitrary and capricious review of plan administrator determinations:

> Plan Administration
>
> The administration of the Long-Term Disability Plan is the shared responsibility of the claims administrator and the Plan Administrator. The claims administrator receives, processes and

> pays all claims for benefits. The claims administrator for the Plan is:
>
> Prudential Life Insurance
>
> . . . .
>
> The Plan Administrator and the claims administrator have the sole discretion and authority to apply, construe and interpret [*811] all Plan provisions, to grant or deny all claims for benefits and to determine all benefit eligibility issues.
>
> . . . . *All decisions or determinations made by the claims administrator and the Plan Administrator will be final and binding on all parties unless such party has acted in an arbitrary and capricious nature.*
>
> The Plan Administrator is an officer of the Company with responsibility for employee benefits, as designated by the Board of Directors
>
> . . .

(emphasis added).

While there is no dispute that the quoted language provides for arbitrary and capricious review, Semien claims that BP never properly delegated its discretionary authority to LINA, the new plan administrator. Unlike several of our sister circuits, this Court has not addressed the question of whether the delegation of a plan administrator's discretionary authority need be express. *See, e.g., Nelson v. EG & G Energy Measurements Group, Inc.*, 37 F.3d 1384, 1388-89 (9th Cir. 1994) (benefit decision by an employee not explicitly given discretion is reviewed de novo); *Sanford v. Harvard Indus., Inc.*, 262 F.3d 590, 597 (6th Cir. 2001)

(when a "decision is made by a body other than the one authorized by the procedures set forth in a benefits plan," the standard of review is de novo); *see also McKeehan v. CIGNA Life Ins. Co.*, 344 F.3d 789, 793 (8th Cir. 2003) ("Insurers are accustomed to de novo judicial review of their decisions, and therefore we do not infer discretionary authority when an employer or plan sponsor has funded its obligations under an ERISA plan by purchasing a standard-form group insurance policy. Rather, we require 'explicit discretion-granting language' in the policy or in other plan documents to trigger the ERISA deferential standard of review." (citations omitted)). Because we find that BP provided LINA with an express delegation of discretionary authority to act as plan administrator, we need not reach the question of whether an implied delegation of authority would be sufficient to shift discretionary authority from the original plan administrator to an insurer.

Semien contends that only the original plan may be considered in determining if LINA is a fiduciary entitled to deference. That contention has been rejected by this Court. *Health Cost Controls of Illinois, Inc. v. Washington*, 187 F.3d 703, 712 (7th Cir. 1999) ("Often the terms of an ERISA plan must be inferred from a series of documents none clearly labeled as 'the plan.'"); *see also Ruiz v. Cont'l Cas. Co.*, 400 F.3d 986, 990-91 (7th Cir. 2005). Under ERISA, fiduciaries are allowed to designate other individuals "to carry out fiduciary responsibilities . . . under the plan." 29 U.S.C. § 1105(c)(1)(B).

In a 2000 Plan Governance Amendment, BP sets out "Procedures for Identification of an Administrative Named Fiduciary." An Administrative Named Fiduciary may be identified by entering into an Administrative Services Agreement with the Plan. LINA entered into an Administrative Services Agreement with the Plan in April 2000. The Administrative Services Agreement states that

"LINA will provide the initial and ongoing screening of claims to determine whether benefits are payable in accordance with the terms of the Plan." Thus, by the terms of the Administrative Services Agreement, LINA agreed to exercise authority over the plan and was granted the same discretionary authority as the original plan administrator.

Additionally, this Court recently stated that the question of whether an administrator is a fiduciary should be "viewed 'in functional terms of control and authority over the plan.'" *Ruiz*, 400 F.3d at 990 (quoting *Mertens v. Hewitt Assocs.*, 508 U.S. 248, 262, [*812] 113 S. Ct. 2063, 124 L. Ed. 2d 161 (1993)). As in *Ruiz*, this Court must determine whether the delegated entity, in this case LINA, was a fiduciary. 29 U.S.C. § 1002(21)(A)(iii) (A fiduciary is a person who "has any discretionary authority or discretionary responsibility in the administration of such plan."). Based upon the language of the Administrative Services Agreement, the district court correctly found that LINA was a fiduciary and had discretionary authority over the administration of the plan. Thus, LINA's decisions as plan administrator are entitled to review under an arbitrary and capricious standard.

B. LINA's Denial of Benefits

On a motion for summary judgment, the moving party must show that there is no genuine issue of material fact and that the moving party is entitled to judgment as a matter of law. FED.R.CIV.P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23, 106 S. Ct. 2548, 91 L. Ed. 2d 265 (1986). In addition, at the summary judgment stage, all inferences are drawn in favor of the non-moving party. *See, e.g., Estate of Moreland v. Dieter*, 395 F.3d 747, 758 (7th Cir. 2005). In this case, to affirm the district court's grant of summary judgment, we must find that when taken in the light most favorable to Semien, there is no evidence LINA's denial of benefits was arbitrary and capricious.

"The arbitrary and capricious standard is the least demanding form of judicial review of administrative action, and any questions of judgment are left to the administrator of the plan. Absent special circumstances such as fraud or bad faith, the [plan administrator's] decision may not be deemed arbitrary and capricious so long as it is possible to offer a reasoned explanation, based on the evidence, for that decision." *Trombetta v. Cragin Fed. Bank for Savings Employee Stock Ownership Plan*, 102 F.3d 1435, 1438 (7th Cir. 1996) (internal citations omitted).

To constitute a full and fair review under 29 U.S.C. § 1133(2), all the evidence that Semien submitted should have been considered by LINA. *See* 29 C.F.R. § 2560.503-1(h)(2)(iv) (Claims procedures must "provide for a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.").

The reports by the physicians LINA hired to review Semien's claim demonstrate a thorough consideration of the available information. These physicians found Semien capable of activities that would disqualify her from long-term disability coverage. Although Semien's treating physicians reached different conclusions as to her abilities, under an arbitrary and capricious review, neither this Court, nor the district court, will attempt to make a determination between competing expert opinions. Instead, an "insurer's decision prevails if it has rational support in the record." *Leipzig v. AIG Ins. Co.*, 362 F.3d 406, 409 (7th Cir. 2004).

The two physician reports prepared for LINA, coupled with the Transferable Skills Analysis prepared based upon those reports, provide a sufficient basis and rational support for the conclusion that Semien was ineligible for long-term disability benefits. While the conclusions in the medical

reports submitted by Semien are also rational, "raising debatable points does not entitle [the claimant] to a reversal under the arbitrary-and-capricious standard." *Sisto v. Ameritech Sickness and Accident Disability Benefit Plan*, 429 F.3d 698, 701 (7th Cir. 2005).

No evidence in the record demonstrates bias by the physicians LINA consulted. [*813] Nor has any evidence been presented to convince this Court that the appraisals by LINA's physicians were so inherently flawed as to be rendered arbitrary and capricious. The confines of the ERISA statute and the constraints of judicial resources do not permit this Court, nor the district courts, to engage in the complex weighing of expert testimony when a plan administrator has been granted discretionary authority. Where an insurance plan gives discretionary authority to a plan administrator, ERISA provides a limited Article III review. Engaging in the type of in-depth review Semien advocates not only runs contrary to statutory intent, but would tax the judicial resources of the district courts and magistrate judges beyond the breaking point.

C. Semien's Discovery Requests

Given our determination that, based upon the evidence in the record, the district court was correct to grant summary judgment, the only remaining question for this Court is whether the record relied upon was complete. Put another way, did the district court err by denying Semien's requests to compel additional discovery?

Semien's discovery requests sought information concerning the relationship between LINA and the physicians paid to evaluate Semien's claim. LINA believed that these discovery requests went beyond the scope of discovery allowed in ERISA cases. The district court agreed and refused to compel discovery.

"It is well-settled that district courts enjoy broad discretion in controlling discovery. A district court's exercise of discretion on discovery matters will only be reversed upon a showing of a clear abuse of discretion." *McCarthy v. Option One Mortgage Corp.*, 362 F.3d 1008, 1012 (7th Cir. 2004) (citing *Leffler v. Meer*, 60 F.3d 369, 374 (7th Cir. 1995)) (internal citation omitted). Generally, parties may obtain discovery regarding any matter that is relevant and not privileged. FED. R. CIV. P. 26(b)(1).

As discussed above, where a plan administrator possesses discretionary authority, the district court reviews his or her decisions under the "deferential 'arbitrary and capricious'" standard. *Mers v. Marriott Int'l Group Accidental Death and Dismemberment Plan*, 144 F.3d 1014, 1019 (7th Cir. 1998) (citing *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 111, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989)).

The district court's denial of Semien's motion to compel discovery relied primarily upon *Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan*, 195 F.3d 975 (7th Cir. 2000). In *Perlman*, this Court articulated its reluctance to grant extensive discovery in ERISA cases:

> When there can be no doubt that the application was given a genuine evaluation, judicial review is limited to the evidence that was submitted in support of the application for benefits, and the mental processes of the plan's administrator are not legitimate grounds of inquiry any more than they would be if the decisionmaker were an administrative agency.

195 F.3d at 982.

A key component of the *Perlman* decision is the first line above, "when there can be no doubt the application was

given a genuine evaluation." *Id.* Thus, *Perlman* distinguishes cases in which no evidence of a failure to conduct a "genuine evaluation" has been presented from those cases in which a prima facie showing of bias or conflict of interest has been made.

When a prima facie showing of misconduct or bias is made, or a claimant demonstrates a good faith basis to believe that limited discovery will produce such evidence, [*814] the district court should engage in a more cautious review. *See Van Boxel v. Journal Co. Employees' Pension Trust*, 836 F.2d 1048, 1053 (7th Cir. 1987). "The existence of a sliding scale in judicial review of ERISA trustees' decisions is suggested by the cases that, while purporting to apply a uniform 'arbitrary and capricious' standard, in fact give less deference to a decision the more the trustees' impartiality can fairly be questioned." *Id.*

When addressing the impact of a conflict of interest under an "arbitrary and capricious" standard of review, the Supreme Court stated, "Of course, if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'factor in determining whether there is an abuse of discretion.'" *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 115, 109 S. Ct. 948, 103 L. Ed. 2d 80 (1989) (quoting RESTATEMENT (SECOND) OF TRUSTS, § 187, Comment *d* (1959)). When "impartiality can fairly be questioned," district courts should allow limited discovery. By allowing limited discovery in cases where a prima facie showing of impropriety has been made, district courts ensure that the "arbitrary and capricious" standard of review is not toothless.

In the instant case, a substantial amount of medical evidence was analyzed by physicians compensated by LINA. These physicians were not employees of the company, they did not fail to analyze relevant medical evidence, and the

claimant has not presented any evidence to demonstrate a prima facie case of misconduct or conflict of interest. The fact that a plan administrator has compensated physicians for their consulting services is not, in and of itself, sufficient to establish a conflict of interest worthy of further discovery. Although a plan administrator's self interest may be a "factor" to "weigh" in evaluating plan determinations, there is no reason to assume independent consultants are not impartial when evaluating medical records. *See Perlman*, 195 F.3d at 981. Thus, we have no basis to believe that the physicians in this case did not conduct a full and fair evaluation of Semien's condition.

When reviewing a plan administrator's decision in the ERISA context, the district court has significant discretion to allow or disallow discovery requests. This is a fact-specific determination and will not be overturned by this Court absent a clear abuse of discretion. *See McCarthy*, 362 F.3d at 1012. The ERISA statute does not "impose on plan administrators a discrete burden of explanation when they credit reliable evidence that conflicts with a treating physician's evaluation," nor should district courts require such an explanation following a claim denial. *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 834, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003).

Decisions by plan administrators are not cloaked with the same level of authority as administrative agency determinations. *See Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2000). Once an ERISA plan grants a plan administrator discretionary authority to evaluate claims, however, the plan administrator's motivations should not be questioned absent a prima facie showing of some misconduct or conflict of interest. *See Perlman*, 195 F.3d at 981-82. Absent this initial showing, the strong warning of *Perlman* remains intact: "We have no reason to think that [a plan administrator's] benefits staff is any more 'partial' against

applicants than are federal judges when deciding income-tax cases." *Perlman*, 195 F.3d at 981.

Although discovery is normally disfavored in the ERISA context, at times additional discovery is appropriate to ensure [*815] that plan administrators have not acted arbitrarily and that conflicts of interest have not contributed to an unjustifiable denial of benefits. In these exceptional cases, where a district court allows limited discovery based upon what appears to be a sustainable allegation, the district court must monitor discovery closely. In this supervisory role, the district court should employ all available tools, including the imposition of Rule 11 sanctions against those who would abuse the discovery process.

Where a claimant makes specific factual allegations of misconduct or bias in a plan administrator's review procedures, limited discovery is appropriate. *See Bruch*, 489 U.S. at 115 (a conflict of interest is a factor to be considered when reviewing a plan administrator's denial of benefits); *see also Van Boxel*, 836 F.2d at 1053 (less deference is appropriate where a trustee's impartiality can be fairly questioned). A claimant must demonstrate two factors before limited discovery becomes appropriate. First, a claimant must identify a specific conflict of interest or instance of misconduct. Second, a claimant must make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's determination. *See Bennett v. Unum Life Ins. Co. of Am.*, 321 F. Supp. 2d 925, 932-33 (E.D. Tenn. 2004) ("Where . . . an ERISA plaintiff comes forward with a reasonable basis to believe that this conflict of interest has solidified into conscious, concrete policies, procedures, and practices to promote the company's financial welfare at the expense of a full and fair evaluation of the plaintiff's claim for benefits, then the plaintiff should be allowed to conduct limited discovery to determine whether such policies, procedures,

and practices do actually exist and, if so, to what extent they interfered with the fair review of the plaintiff's claim for benefits. This information would certainly be relevant to the Court when conducting its review of the decision to deny benefits.").

Semien is correct to note that this standard presents a high bar for individuals whose claims have been denied by a plan administrator with discretionary authority. Discovery will be allowed into the motivations of a plan administrator or into the motivations of "independent" physicians only where the claimant has made a prima facie showing of misconduct or conflict of interest. While this standard essentially precludes discovery without an affidavit or factual allegation, we believe that this approach is the only reasonable interpretation of ERISA. "Like a suit to challenge an administrative decision, a suit under ERISA is a review proceeding, not an evidentiary proceeding." *Doe v. Blue Cross & Blue Shield United of Wis.*, 112 F.3d 869, 875 (7th Cir. 1997). Thus, district courts are correct in limiting discovery except in exceptional circumstances.

Congress has not provided Article III courts with the statutory authority, nor the judicial resources, to engage in a full review of the motivations behind every plan administrator's discretionary decisions. To engage in such a review would usurp plan administrators' discretionary authority and move toward a costly system in which Article III courts conduct wholesale reevaluations of ERISA claims. Imposing onerous discovery before an ERISA claim can be resolved would undermine one of the primary goals of the ERISA program: providing "a method for workers and beneficiaries to resolve disputes over benefits inexpensively and expeditiously." *Perry v. Simplicity Eng'g*, 900 F.2d 963, 967 (6th Cir. 1990) (internal citation omitted). While claimants who believe they are the victims of arbitrary and capricious benefits decisions should feel free to seek relief in

federal court, trial judges must exercise [*816] their discretion and limit discovery to those cases in which it appears likely that the plan administrator committed misconduct or acted with bias.

In the instant case, Semien has presented no prima facie evidence of misconduct or conflict of interest. As a result, the district court lacked good cause to believe that further discovery would reveal misdeeds by LINA or improper motivations on the part of the consulting physicians. Thus, the district court was correct to deny Semien's motion to compel.

III. Conclusion

For the foregoing reasons, the judgment of the district court is AFFIRMED.

**IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION**

KATHLEEN SEMIEN, Plaintiff,

vs.

**LIFE INSURANCE COMPANY
OF NORTH AMERICA, a
CIGNA COMPANY, and BP
LONG TERM DISABILITY
(LTD) PLAN, Defendant.**

03 C 4795

**October 7, 2004, Decided
October 8, 2004, Docketed**

MEMORANDUM OPINION

CHARLES P. KOCORAS, Chief District Judge:

This matter comes before the court on the parties' cross-motions for summary judgment. For the reasons set forth below, the plaintiff's motion for summary judgment is denied and the defendants' motion for summary judgment is granted.

BACKGROUND

Plaintiff Kathleen Semien is a former employee of BP Amoco, the administrator of Defendant BP Long Term Disability Plan ("the Plan"). Defendant Life Insurance Company of North America ("LINA") administers claims made to the Plan for disability benefits. Over the time period at issue in the case, Semien received treatment from her primary care physician, two psychiatrists, two hepatologists, a gastroenterologist, a rheumatologist, a pain specialist, and

a neurosurgeon. Not surprisingly, the team of doctors attending to Semien's care generated an extensive amount of medical information. Though the story they tell is not completely consistent, we summarize a brief chronology here to give an overall flavor of Semien's diagnoses.

In May 2000, Semien began treatment for hepatitis C with a hepatologist named Dr. Conjeevaram. In June 2000, she underwent a cardiologic stress test, which revealed normal heart function though the test stopped short because of Semien's fatigue. In November 2000, Semien began her disability leave, describing her condition as hepatitis C, fatigue, anemia, headaches, nausea, chronic low back pain, muscle pain, rash, hypothyroidism, chronic depression, irritable bowel syndrome, hair loss, mental confusion, and sleep disorder.[4]

In April 2001, Dr. Conjeevaram conducted a basic skills assessment for Semien and concluded that she could perform basic activities for less than 1/3 of an 8-hour workday. In July, Dr. Te, Semien's second hepatologist recorded improvement in her performance, including an ability to process sensory information, reach at desk level, and perform fine manipulation for 2/3 to all of an 8-hour work day. December held further improvement in Semien's condition; a second cardiologic stress test which showed normal heart function and tests for hepatitis C were negative.

In January 2002, Semien underwent spinal surgery to address her continued low back pain. Two months later, Dr. Betman, her primary care physician, echoed Dr. Te's July 2001 basic activity assessment findings. In June, a colonoscopy showed general intestinal health, and a test for hepatitis C showed no evidence of the disease. In July,

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[4] Semien also included an undefined condition called CAD.

Semien received treatment from a Dr. Nagle for carpal tunnel syndrome and examination for other arm pain.

As of August, the end of Semien's two-year initial disability period approached. At that time, one of her psychiatrists, Dr. Skerchock, could not estimate when she would be able to return to work. By October, Dr. Skerchock's assessment had changed somewhat; she concluded that Semien could perform within an adequate range of performance though probably not at her best level for long periods. She stated that she expected that Semien's condition would stabilize through further treatment and medication. This same month, Semien was diagnosed with bone spurs in her cervical spine.

In November 2002, with the end of the initial 24 months imminent, Dr. Betman stated that Semien could gradually return to work at BP Amoco. Dr. Koziol, another psychiatrist seeing Semien concurred, reporting that Semien was stable and responding well to treatment. Dr. Koziol also noted that Semien had clear improvement in her energy level and planned to return to work in January 2003. In slight contrast, Dr. Skerchock stated at this same time that Semien's return date was "in negotiation" but that Semien could perform basic administration or support functions as transitional duty if BP Amoco offered such an option. On November 22, Semien's long-term disability benefits were discontinued on the grounds that the conditions that had given rise to Semien's initial disability determination had been treated successfully and that she was able to perform the duties of her prior occupation.

The following month, Drs. Te, Fintel, and Ruderman (a hepatologist, gastroenterologist, and rheumatologist, respectively) each gave the go-ahead for Semien to return to work in their respective areas of treatment. Dr. Liu, who had performed Semien's back surgery, stated that she should not return to work because of her continuing pain and need for

narcotic medication. On January 7, 2003, LINA received Semien's appeal of the decision to terminate her benefits.

Meanwhile, company medical staff were engaged in a review of Semien's file to determine if she could indeed resume her former duties. They concluded that she could not return to her previous job and terminated her medical leave and her employment on January 30, 2003. The next day, Dr. Skerchock wrote a letter to Dr. Betman, stating that Semien was not employable at all, and Dr. Betman wrote a letter addressed to "whom it may concern" that also stated Semien was unable to sustain full time employment. Semien supplied LINA with additional information about her treatment, including the reports detailed above from Drs. Liu, Nagle, and Koziol, for consideration in the appeal decision.

In May 2003, LINA submitted Semien's file to psychiatric and physical medicine specialists for review and comment on her ability to perform sedentary or light duty occupations. Both doctors concluded that, although Semien could not return to her former employment, there were jobs within her field not precluded by her medical limitations. After receiving the reports of these two physicians, LINA submitted them as the basis for a "transferable skills assessment," whereby an outside company compared Semien's reported limitations with an array of occupations for which she was qualified and that approximated her prior earning level. The results of this assessment stated that Semien could work as a chemical engineer (a position she had held for several years before becoming an environmental business manager with BP Amoco), a chemical research engineer, or an absorption and adsorption engineer. After receiving the reports of the two physicians and the skills assessment, LINA denied Semien's appeal and the denial of benefits became final.

Shortly thereafter, Semien filed the instant suit with LINA as the sole defendant. Discovery proceeded, and the

parties ultimately found themselves before the court on a motion to compel filed by Semien. Not long after the denial of that motion on April 20, 2004, Semien amended her complaint to add the Plan as a defendant. Her motion for summary judgment soon followed, which the defendants countered with a cross-motion for judgment in their favor.

LEGAL STANDARD

Summary judgment is appropriate only if there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. See Fed.R.Civ.P. 56(c); Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 247, 91 L. Ed. 2d 202, 106 S. Ct. 2505 (1986). In seeking a grant of summary judgment the moving party must identify "those portions of the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any' which it believes demonstrate the absence of a genuine issue of material fact ." Celotex Corp. v. Catrett, 477 U.S. 317, 323, 91 L. Ed. 2d 265, 106 S. Ct. 2548 (1986) (quoting Fed.R.Civ.P. 56(c)). This initial burden may be satisfied by presenting specific evidence on a particular issue or by pointing out "an absence of evidence to support the non-moving party's case." Celotex, 477 U.S. at 325. Once the movant has met this burden, the non-moving party cannot simply rest on the allegations in the pleadings, but "must set forth specific facts showing that there is a genuine issue for trial." Fed.R.Civ.P. 56(e). A "genuine issue" in the context of a motion for summary judgment is not simply a "metaphysical doubt as to the material facts," Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp., 475 U.S. 574, 586, 89 L. Ed. 2d 538, 106 S. Ct. 1348 (1986); rather, "[a] genuine issue exists when the evidence is such that a reasonable jury could find for the non-movant," Buscaglia v. United States, 25 F.3d 530, 534 (7th Cir. 1994). When reviewing the record we must draw all reasonable inferences in favor of the non-movant; however, "we are not required to

draw every conceivable inference from the record-only those inferences that are reasonable." Bank Leumi Le-Israel, B.M. v. Lee, 928 F.2d 232, 236 (7th Cir. 1991).

When parties file cross motions for summary judgment, each motion must be assessed independently, and denial of one does not necessitate the grant of the other. M. Snower & Co. v. United States, 140 F.2d 367, 369 (7th Cir. 1944). Rather, each motion evidences only that the movant believes it is entitled to judgment as a matter of law on the issues within its motion and that trial is the appropriate course of action if the court disagrees with that assessment. Miller v. LeSea Broadcasting, Inc., 87 F.3d 224, 230 (7th Cir. 1996). With these principles in mind, we turn to the parties' motions.

DISCUSSION

In ERISA benefit denial cases such as this one, we must first address the issue of the standard of review that applies to the administrator's decision. See, e.g., Morton v. Smith, 91 F.3d 867, 870 (7th Cir. 1996). As LINA points out, we have already visited this topic in the course of deciding the April motion to compel and concluded that the decision had to be examined under the "arbitrary and capricious" standard of review. Semien argues that the key issue in that decision was not what standard would be applied and that we are correspondingly free to apply a de novo standard, which she claims is the correct analysis. We disagree. As our opinion on the motion to compel clearly stated, a decision of the applicable standard of review was a threshold question in deciding the motion to compel. Indeed, the outcome of that motion would have been exactly the opposite if we had concluded that de novo review was appropriate in this case. Semien did not argue the point in her reply brief in support of the motion to compel beyond asserting that the decision was premature, and she did not seek reconsideration of the point when the ruling was issued. As a result, our prior

decision remains the law of the case and dictates the standard that we will apply to today's decision.

In any event, the plan documents afford discretion to the plan administrator to determine benefit eligibility and specifically invoke the arbitrary and capricious standard. See "BP America Long-Term Disability Plan," Appendix to Pl.'s LR 56.1 Statement, Vol. 4, Tab C, p. 10. The Administrative Services Agreement also provided in Tab C evidences the relationship between the plan administrator and LINA such that LINA would screen and process claims to determine benefit eligibility of claimants. As the arbitrary and capricious standard would apply to any decision by the administrator, it would also apply to a decision made by LINA, to whom the administrator had delegated the authority to make such determinations.[5]

When the arbitrary and capricious standard of review applies, "any questions of judgment are left to the administrator of the plan." Trombetta v. Cragin Fed, Bank for Savings Employee Stock Ownership Plan, 102 F.3d 1435, 1438 (7th Cir. 1996). A decision is not arbitrary or capricious unless the party making the decision relies on factors that Congress did not intend to be considered, entirely ignored an important aspect of the particular problem, offers a rationale for its decision that flies in the face of the available evidence, or is so implausible that it cannot be sustained. See id. If it is possible to offer a reasoned explanation of a particular outcome, that outcome

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[5] Semien appears to argue that the Administrative Services Agreement is not valid because the plan itself names Prudential Life Insurance as the claims administrator. However, this is counter to the provisions of the plan itself, which state that both the plan administrator and the claims administrator have authority "to grant or deny all claims for benefits and to determine all benefit eligibility issues." Semien has offered no reason why a delegation of the Plan Administrator's authority, and specifically the one to LINA, under this provision would be invalid.

cannot be deemed to be arbitrary and capricious. See Militello v. Central States, Southeast and Southwest Areas Pension Fund, 360 F.3d 681, 686 (7th Cir. 2004).

The medical information detailed above is undisputed by the parties. It supports, without straining, a conclusion that Semien was capable of performing occupations for which she was qualified as of November 2002. See Ladd v. ITT Corp., 148 F.3d 753, 754 (7th Cir. 1998). The file reflects conflicting opinions of the various medical professionals, but upon its submission to two separate experts for review, the conclusion was the same: Semien was not prevented from returning to a job suitable to her experience and training by her physical or psychiatric limitation. See Leipzig v. AIG Life Ins. Co., 362 F.3d 406, 409 (7th Cir. 2004). Three specific occupations, one of which she had already performed, were identified as being amenable to her situation. While there is certainly evidence within the record that would support a contrary result, one in Semien's favor, its presence or even its greater weight is of no moment under the arbitrary and capricious standard that applies to our review of the decision rendered. See Leipzig v. AIG Life Ins, Co., 362 F.3d 406, 409 (7th Cir. 2004). Consequently, there is no basis to overturn the denial of Semien's benefits.[6] Defendants are entitled to summary judgment in their favor. For the same reasons, Semien's motion for summary judgment must be denied.

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[6] Moreover, in the circumstances of this case, the denial of benefits would survive even if we applied the de novo standard. The medical opinions given by Semien's treating physicians on her myriad conditions are inconsistent at best and contradictory at worst, with some of her doctors even disagreeing with their own diagnoses in a space of as little as two weeks. The concurrence of both independent experts, who examined the medical evidence as a whole, leads us to agree that a denial of benefits was appropriate, even under the more relaxed standard.

Semien also filed a motion to strike two documents offered by Defendants in conjunction with their Local Rule 56.1 Statement of Material Facts. Neither of these documents is found within the record that the administrator considered, and it formed no part of our decision. The motion to strike is accordingly denied as moot.

CONCLUSION

Based on the foregoing analysis, Semien's motion for summary judgment is denied and Defendants' motion for summary judgment is granted. Semien's motion to strike is denied as moot.

Charles P. Kocoras
Chief Judge
United States District Court

Dated: October 7, 2004

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

KATHLEEN SEMIEN, Plaintiff,
vs.
LIFE INSURANCE COMPANY OF NORTH AMERICA, a Cigna company, Defendant.

03 C 4795

April 20, 2004, Decided
April 21, 2004, Docketed

MEMORANDUM OPINION

CHARLES P. KOCORAS, Chief District Judge:

This matter comes before the court on Plaintiff Kathleen Semien's ("Semien") motion to compel discovery. For the reasons set forth below, the motion is denied.

BACKGROUND

Semien worked as a full time employee of BP Corporation ("BP") until May 2000, when she ceased working due to the effects of various medical conditions. Following her departure from BP, Semien filed for disability benefits with Defendant Life Insurance Company of North America ("LINA"), the administrator of the disability insurance coverage plan BP provides for its employees (the "Plan"), including Semien. After affording her disability benefits for almost two years, LINA terminated Semien's benefits on October 22, 2002. LINA's decision to terminate Semien's benefits was based on its determination that Semien is not "disabled." On July 11, 2003, Semien filed suit in this

court under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B), seeking LINA to award her disability benefits to which she is allegedly entitled under the Plan. Discovery is currently under way.

LINA has refused to answer one interrogatory and four document production requests involving certain individuals or entities (many of whom are physicians) that reviewed Semien's claim for benefits and consulted with LINA. Semien seeks discovery relating to the compensation of these individuals, information concerning the frequency with which they have consulted with LINA, and correspondence between these physicians or entities relating to Semien's claims. Semien considers this information relevant to the determination of whether LINA provided a full, fair, and unbiased review of her claims. LINA counters that the information sought by Semien is outside the scope of permissible discovery for ERISA cases of this nature.

LEGAL STANDARD

Because discovery is a search for the truth, the Federal Rules of Civil Procedure ("FRCP") provide a court with broad discretion in resolving discovery disputes. Shapo v. Engle, 2001 U.S. Dist. LEXIS 2223, 2001 WL 629303, *2 (N.D. Ill. 2001). In general "parties may obtain discovery regarding any matter, not privileged, that is relevant to the claim or defense of any party . . .." Fed. R. Civ. P. 26(b)(1). A discovery request should be considered relevant if there is any possibility that the information sought may be relevant to the subject matter of the action. Shapo, 2001 U.S. Dist. LEXIS 2223, [WL] at *2 (citations omitted). In ruling on motions to compel discovery, courts have consistently adopted a liberal interpretation of the discovery rules. Sabratek Liquidating LLC v. KPMG LLP, 2002 U.S. Dist. LEXIS 21858, 2002 WL 31520993, *1 (N.D. Ill. 2002). For these reasons, courts commonly look unfavorably upon significant restrictions placed on the discovery process. Id.

The burden rests on the objecting party to show why a particular discovery request is improper. Id. With these considerations in mind, we now turn to the present motion.

DISCUSSION

Whether LINA had discretionary authority to terminate Semien's benefits is the first question in resolving the present motion to compel. The Plan's Employee Benefits Handbook provides that:

> The decision reached by an individual or entity with authority to respond to appeals is final, conclusive and not subject to further review. The plan administrator (or his authorized delegates) has full and exclusive authority and discretion to:
> . determine the eligibility of any individual to participate in and receive plan benefits; and
> . grant and deny claims under the plan, including the power to interpret the plans.

(Def. Ex. A, p. 6-9). Upon review of this provision, we find that it is of sufficient clarity to grant LINA discretionary authority in determining whether beneficiaries such as Semien are entitled to disability benefits. See Herzberger v. Standard Ins. Co., 205 F.3d 327 (7th Cir. 2000). As such, the appropriate standard of judicial review for this ERISA denial of benefits action is "the deferential 'arbitrary and capricious' one." Mers v. Marriott Int'l. Group Accidental Death and Dismemberment Plan, 144 F.3d 1014, 1019 (7th Cir. 1998) (citing Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 111, 103 L. Ed. 2d 80, 109 S. Ct. 948 (1989)).

In Perlman v. Swiss Bank Corp. Comprehensive Disability Protection Plan, 195 F.3d 975 (7th Cir. 1999)), the Seventh Circuit examined the range of permissible discovery in ERISA cases reviewed under Firestone's "arbitrary and

capricious" standard. The lower court, in reviewing plaintiff Perlman's claim for denial of benefits under the arbitrary and capricious standard, allowed discovery into the plan's decision-making analysis. It permitted discovery into the thought processes of the plan's staff, the training of those who considered Perlman's claims, and "in general who said what to whom" amongst plan officials. Perlman at 981. The Seventh Circuit disagreed. Even though the Seventh Circuit acknowledged that a plan administrator's self-interest is a factor to weigh in evaluating the plan's decision, it "does not affect the standard of review." Id. (citing Firestone at 115). The court noted that just because a plan has a self-interest in expending less on the payment of benefits, its incentives do not necessarily filter down to the individual decision-makers. Id. at 981. Accordingly, absent an indication of impropriety, the scope of discovery is not to be expanded to permit inquiry into the plan's decision-making calculus as "deferential review of an administrative decision means review on the administrative record." Id. at 981-82. The Perlman court held that for this reason:

> When there can be no doubt that the application was given a genuine evaluation [by the plan], judicial review is limited to the evidence that was submitted in support of the application for benefits, and the mental processes of the plan's administrator are not legitimate grounds of inquiry any more than they would be if the decisionmaker were an administrative agency.

Id. at 982. This ruling is consistent with prior Seventh Circuit findings that when the arbitrary and capricious standard applies in ERISA cases, the only relevant materials for discovery are materials that were before the plan administrators when they reached their decision. See

Trombetta v. Cragin Federal Bank for Sav. Employee Stock Ownership Plan, 102 F.3d 1435, 1438, n.1 (7th Cir. 1996). Since Perlman, courts in this district have refused to allow discovery on or to supplement the administrative record with material other than what a beneficiary submitted to a plan in support of his or her claim for benefits. Peltzer v. Life Ins. Co. of North America, 2002 U.S. Dist. LEXIS 14876, 2002 WL 1858786 (N.D. Ill 2002); Heinze v. Life Ins. Co. of North America, 2002 U.S. Dist. LEXIS 8661, 2002 WL 977434 (N.D. Ill. 2002).

Upon review of Semien's discovery requests, we find that they seek information that is squarely beyond the scope of permissible discovery under Perlman. While Semien cites a recent Supreme Court case, Black & Decker v. Nord, 538 U.S. 822, 123 S. Ct. 1965, 155 L. Ed. 2d 1034 (2003), wherein dicta relays a concern that plans may have a financial incentive to deny beneficiaries' claims, the case is neither on point nor controlling over the limits of discovery in denial of benefits cases. Also, Semien offers no indication, other than the fact's the LINA's consultants are paid for their services, that Semien's decision-makers would be biased against her. Because the information sought by Semien, namely the motivation and potential bias behind LINA affiliates, is material outside the administrative record that concerns the mental processes on which LINA's decision was based, discovery on the subject is impermissible under Perlman.

CONCLUSION

Based on the foregoing analysis, Semien's motion to compel discovery is denied.

Charles P. Kocoras

Chief Judge

United States District Court

(3)

Supreme Court, U.S.
FILED
AUG 21 2006
OFFICE OF THE CLERK

No. 05-1386

IN THE

Supreme Court of the United States

KATHLEEN SEMIEN,
Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, A CIGNA COMPANY, AND BP LONG TERM DISABILITY (LTD) PLAN,
Respondents.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Seventh Circuit

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Counsel for Respondents

QUESTION PRESENTED

The employee benefit plan in which petitioner is a member provides its administrator with discretion in determining eligibility for benefits. The claims administrator in this case reviewed petitioner's medical file (which included numerous statements of petitioner's own physicians indicating she was able to return to work in light or reduced capacities) and consulted with two independent medical professionals and an occupational health specialist, all three of whom also reviewed petitioner's file. Based on its review of the claim record, the administrator denied petitioner's claim for an extended long-term disability benefit.

In a subsequent judicial challenge, both courts below held that petitioner failed to point to anything in the claim record before the administrator demonstrating that its benefit determination was arbitrary or capricious. Indeed, the district court held that, even if review of the administrator's decision had been *de novo*, the court would have upheld the benefit denial.

The question properly presented is:

Whether this Court should grant certiorari to review the decisions below holding that petitioner failed to demonstrate that the administrator's benefit determination was arbitrary and capricious, where (a) the decisions below apply settled legal rules and implicate no circuit conflict, (b) both courts found that that, on the particular facts of this case, petitioner was not entitled to discovery beyond the record presented to the administrator, and (c) the district court held that it would have rejected petitioner's benefit claim even on *de novo* review.

RULE 29.6 STATEMENT

Respondent Life Insurance Company of North America is owned by Connecticut General Corporation, which is owned by Cigna Holding, Inc., which is owned by CIGNA Corporation. Respondent BP Long Term Disability (LTD) Benefit Plan is not a corporation.

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INTRODUCTION

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), this Court held that when an employee benefit plan vests the plan administrator with discretion to interpret and enforce the plan, the administrator's benefit determination is reviewed in a subsequent challenge under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), only for abuse of discretion, and must be upheld under that standard unless it is found to be arbitrary and capricious. 489 U.S. at 110-11. In the wake of *Firestone*, every federal circuit has held that such arbitrary and capricious review is to be conducted on the basis of the claims record presented to the administrator. *See infra* at 11-12. Applying those settled principles here, both courts below held that petitioner failed to point to anything in the claim record before the administrator demonstrating that the denial of petitioner's claim to an extended long-term disability benefit was arbitrary and capricious.

Nothing about this case warrants review by this Court. The district court's judgment is a straightforward, factbound application of firmly settled law governing the adjudication of benefit claims under ERISA § 502(a)(1)(B). The Seventh Circuit's affirmance of that judgment does not conflict with any decision of this Court or of any other circuit. The petition's contrary suggestion simply reflects a misunderstanding of both the decision below and the substantive legal standards governing that decision. Finally, a decision by this Court will have no effect on the disposition of this case, because the most petitioner seeks is more searching judicial scrutiny of the administrator's benefit determination, and the district court has *already* held that even under a *de novo* standard, the denial of petitioner's request for benefits would stand. Accordingly, any decision by this Court would be at best advisory in this case.

This case is, in short, a most unworthy candidate for certiorari. The petition should be denied.

STATEMENT OF THE CASE

This case arises out of a claim for long-term disability ("LTD") benefits that petitioner Kathleen Semien filed after leaving her job at BP Amoco ("BP"). Petitioner received LTD benefits for an initial two-year period, but at the end of that period respondent Life Insurance Company of North America ("LINA") determined that she did not meet the qualifications for a second, extended LTD benefit under the terms of the benefit plan LINA administered. Petitioner pursued her internal plan appeals and then sued under ERISA, seeking an order establishing her entitlement to the extended LTD benefit. Both the district court and the Seventh Circuit rejected her claim. This petition followed.

A. Factual Background

1. Petitioner began working for BP in February 1989 as an environmental remediation manager. Pet. App. 2a. She was employed as a chemical engineer when she left BP on May 15, 2000. *Id.*

2. BP sponsored a Consolidated Welfare Benefits Plan ("the Plan") that provided LTD benefits to eligible employees. *Id.* LINA functioned as the claims administrator for the plan pursuant to an administrative services agreement with BP. *Id.* at 2a-3a. Under that agreement, LINA was responsible for processing claims for benefits under the Plan, including the ultimate determination whether a claim satisfied the Plan's requirements for payment of benefits. *Id.* at 3a. LINA also insured the benefits provided through the Plan. *Id.*

Under the terms of the Plan, a participant was entitled to receive LTD benefits for 24 months upon a showing that she "could not perform her 'Regular Occupation or a Qualified Alternative.'" *Id.* "After the initial 24-month period, a more stringent standard applied." *Id.* A participant was eligible for an extended LTD benefit if, "solely because of Injury or

Sickness," she was (1) unable to perform all the material duties of any occupation for which she was or could reasonably become qualified or (2) unable to earn 80% or more of her prior earnings. *Id.* at 4a-5a.

The Plan also conferred on the administrator complete discretionary authority over the administration of plan benefits, including final benefit determinations:

> The plan administrator (or his authorized delegates) has full and exclusive authority and discretion to:
>
> ◦ determine the eligibility of any individual to participate in and receive plan benefits; and
>
> ◦ grant and deny claims under the plan, including the power to interpret the plans.

Id. at 31a.

3. Petitioner made her initial claim for LTD benefits in September 2000, four months after leaving BP. *Id.* at 3a. She claimed that she suffered from a number of medical conditions, including back pain, a herniated lumbar disk, bone spurs in her neck, carpal tunnel syndrome, problems in her joints and extremities, fibromyalgia, and past sickness as a result of Hepatitis C. *Id.* She also asserted that she suffered from chronic depression, suicidal thoughts, and mental confusion. *Id.*

LINA approved petitioner's initial claim for LTD benefits in November 2000, on the grounds that she was suffering from side effects from hepatitis C, medication, fatigue, and pain, and thus could not perform her regular occupation or a qualified alternative. *Id.* LINA stated, however, that it would continue to monitor petitioner's condition and request additional medical records on an ongoing basis to ensure eligibility. *Id.* Further, LINA approved petitioner's claim only for the initial 24-month benefit period. *Id.*

During the two-year initial period, petitioner submitted additional medical documentation to LINA, including assessments performed by her own physicians. *Id.* at 3a-4a. Most of those assessments stated that petitioner was capable of performing moderate work, even though her abilities were limited. *Id.* at 4a; *see also* Resp. C.A. Br. 4-8 (collecting record cites).

By the end of the two-year initial period, most of petitioner's doctors had concluded that she was able to return to work. "Drs. Te, Fintel, and Ruderman (a hepatologist, gastroenterologist, and rheumatologist, respectively) each gave the go-ahead for Semien to return to work." Pet. App. 22a. One of her psychiatrists, Dr. Skerchock, "concluded that Semien could perform within an adequate range of performance" and "expected that Semien's condition would stabilize through further treatment and medication." *Id.* Dr. Skerchock's treatment notes indicated that petitioner repeatedly stated her desire to return to work. D. Ct. Dkt. #20, at 24-27; Dkt. #25, ¶ 35. Another psychiatrist, Dr. Koziol, "noted that Semien had clear improvement in her energy level and planned to return to work." Pet. App. 22a. Dr. Betman, petitioner's primary care physician, stated that she "could gradually return to work." *Id.*[1] Only Dr. Liu, who had performed surgery on petitioner's back in January 2002, suggested that she should not return to work because of her "continuing pain" and "need for narcotic medication." *Id.* at 22a-23a.

4. As the November 2002 end of the initial benefit period approached, the medical information submitted by petitioner to LINA was reviewed by a Nurse Care Manager and a Behavior Care Specialist. *Id.* at 4a. In a letter dated No-

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[1] After LINA reviewed petitioner's eligibility for continued benefits and determined that she was no longer eligible, however, "Dr. Skerchock wrote a letter to Dr. Betman stating that Semien was not employable at all," and Dr. Betman wrote a letter stating that she was "unable to sustain full time employment." Pet. App. 23a.

vember 22, 2002, LINA notified petitioner that the medical information she had provided did not establish her qualification for the extended LTD benefit. *Id.* (quoting letter stating that "the medical documentation does not support your inability to perform your occupation as an Environmental Business Manager").

5. Petitioner filed an internal appeal of the denial of benefits. *Id.* at 5a. To review her appeal, LINA retained several independent experts, including an independent psychiatrist, Dr. Jack Greener; an independent physician, Dr. Eddie Sassoon; and an independent senior rehabilitation counselor and vocational expert, Lynne Lonberg. *Id.* at 5a-6a.

"Both doctors concluded that, although Semien could not return to her former employment, there were jobs within her field not precluded by her medical limitations." *Id.* at 23a. Dr. Greener reviewed petitioner's medical records and concluded in a detailed fourteen-page report that she had moderate to severe depression but that she would be able to perform a sedentary to light job that did not have irregular or unplanned hours, emergency situations, or travel. *Id.* at 5a. Dr. Sassoon separately reviewed petitioner's records and independently concluded that she was capable of performing a sedentary or light duty occupation. *Id.* Lonberg conducted a "Transferable Skills Analysis" based on the reports of Dr. Greener and Dr. Sassoon and determined that there were several occupations that petitioner could perform based on her education, skills, and physical and mental abilities, including working as a chemical engineer, a chemical research engineer, or an adsorption and absorption engineer. *Id.* at 6a.

On June 27, 2003, on the basis of the independent doctors' reports and the vocational skills assessment, LINA affirmed the initial determination that petitioner did not qualify for LTD benefits under the Plan terms applicable after the initial 24-month period. *Id.*

B. Proceedings Below

1. Petitioner filed suit in federal district court under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), seeking an order requiring the Plan and LINA to provide her the Plan's extended LTD benefit. Pet. App. 6a.

2. In proceedings before the district court, petitioner sought discovery from LINA on a variety of matters. Pet. App. 6a. In response LINA provided petitioner with the entire administrative record, but objected to discovery beyond the scope of that record, including discovery into the relationship between LINA and the physicians it consulted. *Id.* The district court denied petitioner's motion to compel discovery into these matters. *Id.* at 31a-33a.

The district court's discovery opinion first notes that because the Plan gave LINA "discretionary authority to determine whether beneficiaries such as Semien are entitled to disability benefits," LINA's benefit determination would be reviewed under the deferential "arbitrary and capricious" standard of review, consistent with this Court's decision in *Firestone*. *Id.* at 31a. The opinion further notes that while "a plan administrator's self-interest is a factor to weigh in evaluating the plan's decision," discovery into defects or bias in the decisionmaking process is not automatic, but requires some threshold "indication of impropriety." *Id.* at 32a; *see id.* (discovery into bias is not appropriate when "there can be no doubt that the application was given a genuine evaluation" by the plan (internal quotation marks omitted)). Because petitioner "offer[ed] no indication, other than the fact[] [that] LINA's consultants are paid for their services, that Semien's decision-makers would be biased against her," petitioner's request for material exceeding the scope of the claims record was denied. *Id.* at 33a. Accordingly, the court limited the trial record to the "materials that were before the plan administrators when they reached their decision." *Id.* at 32a.

The parties subsequently filed cross-motions for summary judgment. The district court entered summary judgment for LINA and the Plan, upholding LINA's determination that petitioner no longer qualified for disability benefits. The court first reviewed the medical evidence submitted by petitioner. The court noted that, by the end of her initial two-year benefit period, most of her doctors, including her primary care physician, had determined that she could return to work. Pet. App. 22a-23a.

The district court again noted that arbitrary and capricious review applied because "the plan documents afford discretion to the plan administrator to determine benefit eligibility and specifically invoke the arbitrary and capricious standard." Pet. App. 26a. The court then reviewed the undisputed medical evidence in the record and determined that "it supports, without straining, a conclusion that Semien was capable of performing occupations for which she was qualified as of November 2002." *Id.* at 27a. It noted that although there were some "conflicting opinions" among petitioner's various doctors, "two separate experts" reviewed all of those opinions and came to the same conclusion, which was that "Semien was not prevented from returning to a job suitable to her experience and training by her physical or psychiatric limitation." *Id.* "Three specific occupations, one of which she had already performed, were identified as being amenable to her situation." *Id.* Thus, there was "no basis to overturn the denial of Semien's benefits." *Id.*

Importantly, the district court noted that petitioner would not be entitled to relief *even under de novo review*:

> [I]n the circumstance of this case, the denial of benefits would survive even if we applied the de novo standard. The medical opinions given by Semien's treating physicians on her myriad conditions are inconsistent at best and contradictory at worst, with some of her doctors even disagreeing with their own diagnoses in the space of as

> little as two weeks. The concurrence of both independent experts, who examined the medical evidence as a whole, leads us to agree that a denial of benefits was appropriate, even under the more relaxed standard.

Id. at 27a n.6.

3. A unanimous panel of the Seventh Circuit affirmed, in an opinion by Judge Flaum (joined by Judge Bauer and Judge Evans). The court of appeals first confirmed that LINA's denial of benefits was properly reviewed under the arbitrary and capricious standard, rather than *de novo*, because the Plan and administrative services agreement "clearly and unequivocally" granted discretion to LINA as the claims administrator. Pet. App. 7a (quoting *Perugini-Christen v. Homestead Mortgage Co.*, 287 F.3d 624, 626 (7th Cir. 2002)).

Applying the arbitrary and capricious standard, the court of appeals determined that, construing all facts in the summary judgment record in favor of petitioner, there was no basis for overturning LINA's decision. Pet. App. 11a. The court noted that the physicians LINA consulted gave "thorough consideration" to all of the evidence that Semien submitted and concluded that she was capable of performing certain jobs. *Id.* at 12a. Although some of petitioner's doctors reached different conclusions, there was "no evidence in the record" suggesting that the independent physicians were biased or that their appraisals were "so inherently flawed as to be rendered arbitrary and capricious." *Id.* at 13a.

The court of appeals also addressed petitioner's claim that she was entitled to further discovery regarding the relationship between LINA and the physicians it consulted. The court noted that it is "reluctan[t] to grant extensive discovery in ERISA cases" where "'there can be no doubt that the application [for benefits] was given a genuine evaluation.'" Pet. App. 14a (quoting *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 982 (7th Cir.

2000)). But the court recognized that when an administrator's "impartiality can fairly be questioned, district courts should allow limited discovery." Pet. App. 15a-16a (internal quotation marks omitted). The purpose of that discovery is to "ensure that . . . conflicts of interest have not contributed to an unjustifiable denial of benefits." *Id.* at 17a.

The Seventh Circuit explained the particular circumstances that could justify limited discovery: "Where a claimant makes specific factual allegations of misconduct or bias in a plan administrator's review procedures, limited discovery is appropriate." *Id.* A claimant must (1) "identify a specific conflict of interest or instance of misconduct" and (2) "make a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's decision." *Id.* In this case, however, petitioner "presented no prima facie evidence of misconduct or conflict of interest," and thus the court of appeals affirmed the denial of her motion to compel discovery. *Id.* at 19a.

REASONS FOR DENYING THE PETITION

Petitioner seeks certiorari to address a single question, *viz.*, whether "the Article III powers of a district court in adjudicating a civil action [under ERISA § 502(a)(1)(B)] are limited to conducting a review proceeding." Pet. i. Petitioner's Question Presented reveals a basic misunderstanding of the settled law governing § 502(a)(1)(B) actions. Properly understood, the issue petitioner is attempting to raise was squarely answered by this Court in *Firestone*, a decision followed faithfully in this case by the courts below. Nothing about the trial court's factbound application of deferential review under *Firestone*, or the Seventh Circuit's affirmance of that judgment, warrants review by this Court.

A. The Review Standard Applied Below Is Perfectly Consistent With This Court's Precedents And Implicates No Circuit Conflict

Petitioner's central argument is that the decision below conflicts with ERISA's text and legislative history, and with an opinion of this Court involving Title VII, simply because the opinion analogizes a judicial action under ERISA § 502(a)(1)(B) to an administrative "review proceeding." Pet. 10. According to petitioner, ERISA authorizes "a plenary court proceeding" in all § 502(a)(1)(B) challenges, and thus the trial record cannot be limited to the claims record presented to the administrator. *Id.*

Petitioner is wrong. Equally important, her contention raises no issues that are the subject of legal controversy in the circuits.

1. *The Decisions Below Follow This Court's Decision In* Firestone *And Uniformly Recognized Principles Of Arbitrary And Capricious Review*

ERISA § 502(a)(1)(B) creates a federal civil action "to recover benefits due . . . under the terms" of an ERISA-governed employee benefit plan. 29 U.S.C. § 1132(a)(1)(B). This Court held in *Firestone*, however, that where – as here – the plan confers discretion on the plan administrator, the administrator's benefit determination is subject to review in a § 502(a)(1)(B) action only for abuse of discretion, and will be set aside under that standard only if shown to be arbitrary and capricious. 489 U.S. at 110-11. According to this Court, that rule follows directly from the statute itself: ERISA codifies "certain principles developed in . . . the law of trusts," and "[t]rust principles make a deferential standard of review appropriate when a trustee exercises discretionary powers." *Id.* (internal quotation marks omitted). The substantive review standard applied in a § 502(a)(1)(B) is thus plainly not "plenary" – it is the most deferential standard that can be applied in a judicial proceeding. *See Williams v. Int'l*

Paper Co., 227 F.3d 706, 712 (6th Cir. 2000) ("the arbitrary and capricious standard is the least demanding form of judicial review").[2]

Further, *every* federal circuit agrees with the decision below that, in adjudicating a § 502(a)(1)(B) challenge subject to the deferential arbitrary and capricious review standard, the district court should limit itself to reviewing the same claim record presented to the plan administrator. "The ordinary rule is that review for arbitrariness is on the record made before the entity being reviewed." *Liston v. UNUM Corp. Officer Severance Plan*, 330 F.3d 19, 23 (1st Cir. 2003); *see Miller v. United Welfare Fund*, 72 F.3d 1066, 1071 (2d Cir. 1995); *Mitchell v. Eastman Kodak Co.*, 113 F.3d 433, 440 (3d Cir. 1997); *Elliott v. Sara Lee Corp.*, 190 F.3d 601, 608 (4th Cir. 1999); *Vega v. Nat'l Life Ins. Servs.*, 188 F.3d 287, 300 (5th Cir. 1999); *Univ. Hosps. of Clev. v. Emerson Elec. Co.*, 202 F.3d 839, 848 n.7 (6th Cir. 2000); *Perlman v. Swiss Bank Corp. Comprehensive Disability Prot. Plan*, 195 F.3d 975, 981-82 (7th Cir. 1999); *Cash v. Wal-Mart Group Health Plan*, 107 F.3d 637, 641 (8th Cir. 1997); *Taft v. Equitable Life Assurance Soc'y*, 9 F.3d 1469, 1471 (9th Cir. 1993); *Sandoval v. Aetna Life & Cas. Ins. Co.*, 967 F.2d 377, 380 (10th Cir. 1992); *Lee v. Blue Cross/Blue Shield of Ala.*, 10 F.3d 1547, 1550 (11th Cir. 1994); *Block v. Pitney Bowes, Inc.*, 952 F.2d 1450, 1455 (D.C. Cir. 1992). This rule rests on the sound principle that "[p]ermitting a district court to examine evidence outside the administrative record would open the door to the anomalous conclusion that a plan administrator abused its discretion by failing to con-

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[2] The federal courts of appeal have labeled the standard of review when a plan administrator has discretionary authority both "abuse of discretion" review and "arbitrary and capricious" review. *Block v. Pitney Bowes Inc.*, 952 F.2d 1450, 1454 (D.C. Cir. 1992). "The distinction, if any, between 'arbitrary and capricious review' and review for 'abuse of discretion' is subtle." *Id.* Because the Seventh Circuit generally refers to "arbitrary and capricious" review, this brief does the same.

sider evidence not before it." *Taft*, 9 F.3d at 1472; *see Liston*, 330 F.3d at 23-24 ("[H]ow could an administrator act unreasonably by ignoring information never presented to it?"). The general rule also "keep[s] district courts from becoming substitute plan administrators." *Cash*, 107 F.3d at 641-62 (internal quotation marks omitted). In short, so long as the administrator's decision is within the range of conclusions permissible on the basis of the record before it, the decision cannot be deemed arbitrary and capricious. *See Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163, 168-69 (2d Cir. 2001) ("discretion" means decisionmaker has authority "to make a decision – of its choosing – that falls within a range of permissible decisions").[3]

The courts – including the Seventh Circuit – also recognize that district courts adjudicating challenges under the arbitrary and capricious review standard must actually review the evidence that was before the plan administrator. As the Sixth Circuit opinion quoted by petitioner correctly observes, arbitrary and capricious review "inherently includes some review of the quality and quantity of the medical evidence and the opinions on both sides of the issue." Pet. 17 (quoting *McDonald v. W.-S. Life Ins. Co.*, 347 F.3d 161, 172 (6th Cir. 2003)). But this means only that the court must "review *the administrative record*," 347 F.3d at 172 (emphasis added) – not conduct a *de novo* factfinding proceeding ranging beyond the claims record actually submitted to the administra-

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[3] None of the circuits has held, however, that there is an *absolute* bar to discovery when the plan administrator's determination is reviewed under the arbitrary and capricious standard. *E.g.*, *Liston*, 330 F.3d at 23 ("we have declined . . . to adopt an ironclad rule against new evidence"). The courts of appeal have instead described a variety of circumstances in which district courts may consider evidence beyond the administrative record, such as when "the decision process is too informal to provide a record," *id.* at 23; when external evidence is required to "interpret[] the plan or explain[] medical terms and procedures relating to the claim," *Vega*, 188 F.3d at 299; or when the administrator apparently did not conduct a "genuine evaluation," *Perlman*, 195 F.3d at 982.

tor. This Court made precisely the same point in another decision cited by petitioner, *Motor Vehicle Manufacturers Ass'n v. State Farm Mutual Automobile Insurance Co.*, 463 U.S. 29 (1983), which holds that an agency's decision is deemed arbitrary and capricious if it lacks a reasoned and logical connection to the *facts and evidence before the agency*. *Id.* at 43.

The decisions below adhere faithfully to these standard principles of arbitrary and capricious review. The district court's opinion details at length the medical information submitted to the claims administrator. Pet. App. 21a-23a. Analyzing that information, the opinion specifically describes the conflicting views of petitioner's own doctors, as well as the consistent views of the independent professionals who reviewed her file. *Id.* at 27a & n.6. The court of appeals' opinion likewise describes all the evidence in the claims record, including both the statements of petitioner's doctors and the conclusions of the independent consulting professionals, *id.* at 3a-6a, and concludes that nothing in that record establishes that LINA's decision denying her eligibility for extended LTD benefits was arbitrary and capricious, *id.* at 13a. In no respect do the factbound decisions below conflict with any decision of this Court or of any other circuit addressing the basic standards governing review of discretionary benefit determinations in § 502(a)(1)(B) actions.

2. *The Decision Below Does Not "Exempt" ERISA Actions From The Rules Of Procedure Generally Governing All "Civil Actions"*

The foregoing discussion also refutes petitioner's absurd contention that the decision below "exempts ERISA cases from the Federal Rules of Civil Procedure" (Pet. 18) in favor of a "quasi-administrative law" scheme (*id.* at 21). *See also* AARP Br. 5-6, 9. Petitioner's contention rests entirely on the fact that courts adjudicating *discretionary* benefit determinations provide only limited, arbitrary and capricious re-

view. As just explained, however, that review standard is mandated by this Court's decision in *Firestone* and by the trust principles underlying ERISA. Further, there is no tension between following the *procedural* rules applicable to any civil action and adjudicating an action according to the *substantive* rule of review mandated by *Firestone*. This case illustrates the point: the trial court's summary judgment order was the product of a standard civil action governed by the Federal Rules, with discovery into matters relevant in this type of action, i.e., discovery of the entire administrative claims record. Neither decision below suggests in any way that these actions were "exempt" from the Federal Rules.

There is thus plainly no conflict between the decision below and the various decisions cited by petitioner holding that courts must provide full, *de novo* review in civil actions arising under *other* statutes. The principal case petitioner cites, *Chandler v. Roudebush*, 425 U.S. 840 (1976), holds that claims brought under Title VII must be considered *de novo* by the district court, even when there has been a prior administrative proceeding. *Id.* at 845. But that simply is not the substantive rule governing this proceeding: as already discussed, this case is controlled by *Firestone*, which holds that ERISA § 502(a)(1)(B) challenges are *not* reviewed *de novo* where – as here – the administrator has discretion.

New Hampshire Fire Insurance Co. v. Scanlon, 362 U.S. 404 (1960), is even farther afield. That case simply holds that tax levy cases must be treated as "civil actions" governed by the Federal Rules. *Id.* at 406. As noted, the proceedings in this case *were* governed by the Federal Rules, even while the substantive rule of decision was dictated by the terms of the Plan and by *Firestone*.

Richardson v. Perales, 402 U.S. 389 (1971), likewise has nothing to do with this case. *Richardson* involves the quantum of evidence required in an administrative proceeding for benefits under the Social Security Act – not the judicial stan-

dard of review applicable to a discretionary benefit determination made by the administrator of a private employee benefit plan. This Court has specifically recognized the "critical differences between the Social Security disability program and ERISA benefit plans" that "caution against" importing rules "from the former area into the latter." *Black & Decker Disability Plan v. Nord*, 538 U.S. 822, 832-33 (2003). Petitioner herself notes the distinction. Pet. 22. And this Court in *Firestone* settled the rule applicable to review of an ERISA plan's discretionary benefit determination: so long as the administrator's decision is not arbitrary and capricious – that is, so long as the decision reflects a rational conclusion from the claims record – it must be upheld. *See supra* at 10-13. The rules applicable to a Social Security proceeding have no relevance here.

Petitioner also asserts a conflict with *Nord* (Pet. 23), but that decision, if anything, strongly *supports* the decision below. *Nord* holds that a plan administrator is not required to give special weight to the opinion of a claimant's treating physician as to the claimant's disability. 538 U.S. at 834. In so doing *Nord* applies the basic rule of arbitrary and capricious review that so long as the decisionmaker's judgment finds support in claims record evidence reasonably deemed reliable, the decision must be upheld by a reviewing court. *Id.* Both courts in this case properly applied that standard.

3. *The Decision Below Implicates No Conflict Over The Standard For Discovery Into A Benefit Plan Decisionmaker's Alleged Bias*

Finally, there is also no conflict over the standard applicable to requests for discovery into whether or not the benefit determination was affected by bias on the part of the decisionmaker. Pet. 18-20. According to petitioner, "the Seventh Circuit stands alone" in respect to discovery into potential bias. *Id.* at 19. Not so.

To start, the circuit-court opinions that have mentioned this issue all agree that bias or corruption may sometimes be a relevant area of inquiry outside the claims record. *See Liston*, 330 F.3d at 23; *Zervos v. Verizon N.Y., Inc.*, 252 F.3d 163, 174 (2d Cir. 2001); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 395 (3d Cir. 2000); *Calvert v. Firstar Fin., Inc.*, 409 F.3d 286, 293 n.2 (6th Cir. 2005); *Farley v. Ark. Blue Cross & Blue Shield*, 147 F.3d 774, 776 n.4 (8th Cir. 1998); *Abatie v. Alta Health & Life Ins. Co.*, 2006 U.S. App. Lexis 20829, at *36 (9th Cir. 2006). And even those comments appear only in dicta – there are no square holdings on this issue in any other circuit (i.e., no published decisions reversing or affirming a district court decision on whether to allow such discovery). There is thus no conflict in legal standards justifying certiorari. *See* Robert L. Stern et al., *Supreme Court Practice* 225 (8th ed. 2002) ("there must be a real or 'intolerable' conflict on the same matter of law or fact, not merely an inconsistency in dicta or in the general principles utilized").

What is more, none of the foregoing decisions establishes that discovery into bias is automatic every time a plaintiff seeks it. As in all discovery matters, a district court considering a request for discovery into bias "is to be guided by its sound discretion." *Tremain v. Bell Indus.*, 196 F.3d 970, 978 (9th Cir. 1999); *see also Kosiba v. Merck & Co.*, 384 F.3d 58, 67 n.5 (3d Cir. 2004), *cert. denied*, 544 U.S. 1044 (2005). The few decisions that have squarely addressed district court holdings on the issue have held that the denial of discovery was an appropriate exercise of discretion. *See, e.g., Scardelletti v. Debarr*, 43 Fed. Appx. 525, 528 (4th Cir. 2002) (unpublished opinion) ("The record demonstrates that the district court was adequately informed as to the factual basis for Devlin's conflict of interest and . . . did not abuse its discretion in declining to allow Devlin discovery."); *Kaus v. Standard Ins. Co.*, 1998 WL 778055, at *3 (10th Cir. 1998) (unpublished opinion) (plaintiff "failed to establish

that it would be appropriate to consider evidence outside of the administrative record" regarding an alleged conflict of interest).[4]

The Seventh Circuit's decision below is entirely consistent with the dicta and decisions from other circuits indicating that discovery into bias may be appropriate, but only in the proper factual circumstances. As the court of appeals explained, while discovery beyond the claims record normally is not allowed in "cases in which no evidence of a failure to conduct a 'genuine evaluation' has been presented," the situation is different when "a prima facie showing of bias or conflict of interest has been made." Pet. App. 15a. In the latter case, additional discovery may be appropriate:

> Although discovery is normally disfavored in the ERISA context, at times additional discovery is appropriate to ensure that plan administrators have not acted arbitrarily and that conflicts of interest have not contributed to an unjustifiable denial of benefits. . . . Where a claimant makes specific factual allegations of misconduct or bias in a plan administrator's review procedures, limited discovery is appropriate.

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[4] Petitioner cites three other decisions as conflicting with the decision below on the discovery standard, but these decisions are categorically inapplicable. Two of the decisions, *Tremain* and *Moon v. American Home Assurance Co.*, 888 F.2d 86 (11th Cir. 1989), involved cases of *de novo* review of an administrator's determination, and thus do not bear on this case, which involves discovery into bias when arbitrary and capricious review applies. In any event, both *Tremain* and *Moon* state that discovery may be appropriate in considering a conflict of interest, just as the Seventh Circuit did here. *Tremain*, 196 F.3d at 977; *Moon*, 888 F.2d at 89. Petitioner also cites *Kergosien v. Ocean Energy, Inc.*, 390 F.3d 346 (5th Cir. 2004), but that case holds that an *arbitrator* may go outside the administrative record in considering an alleged conflict of interest, 390 F.3d at 351-53; it offers no guidance on what discovery might be appropriate when a district court is reviewing a claim for benefits under ERISA § 502(a)(1)(B).

Id. at 17a. According to the decision below, discovery into bias is appropriate where the plaintiff (1) "identif[ies] a specific conflict of interest or instance of misconduct" and (2) "make[s] a prima facie showing that there is good cause to believe limited discovery will reveal a procedural defect in the plan administrator's decision." *Id.*

Applying that standard to the particular facts of this case, the court affirmed the district court's judgment that discovery into bias was not justified here. As the court explained, "the district court has significant discretion to allow or disallow discovery requests," but petitioner "ha[d] presented no prima facie evidence of misconduct or a conflict of interest" and thus was not entitled to discovery. *Id.* at 16a, 19a.

For the reasons explained, that factbound ruling raises no circuit conflict justifying review. While the merits of the Seventh Circuit's approach are thus largely beside the point, it bears noting that, contrary to petitioner's suggestion (Pet. 19), the flexible standard applied in the Seventh Circuit does not preclude plaintiffs from obtaining evidence needed to support genuine claims of bias or corruption. Petitioner herself admits that the Seventh Circuit does not bar discovery (*id.*); it simply requires a showing that discovery would be likely to produce relevant and admissible evidence of bias or corruption. Where, for example, the terms of the plan itself create a prima facie inference of bias, *see, e.g.*, *Pegram v. Herdrich*, 530 U.S. 211, 227 n.7 (2000) (citing example of plan providing "a bonus for administrators who denied benefits to every 10th beneficiary"), or it appears from the administrative record that the decisionmaker did not conduct a genuine evaluation, *see Perlman*, 195 F.3d at 982, a plaintiff might be entitled to discovery seeking to determine the extent to which bias or corruption affected the benefit determination. Indeed, district courts applying the Seventh Circuit's standard have allowed discovery to explore alleged conflicts of interest, *see, e.g.*, *Fowler v. Williams Cos.*, 2005 U.S.

Dist. Lexis 5025, at *6-7 (W.D. Wis. 2005), demonstrating the fairness and flexibility of the standard.

B. Petitioner's Claim For Benefits Would Fail Even If She Obtained The Relief Requested From This Court

Even if petitioner's Question Presented implicated any concrete legal controversies worthy of review by this Court, this case would be an inappropriate vehicle for resolving them, because any decision by this Court would have no effect on the ultimate disposition of the case. *See* Stern et al., *supra*, at 457 (case "presents a poor vehicle for resolving a conflict" where case "would be decided in favor of the respondent no matter how the conflict is resolved"). The most petitioner could possibly obtain through further review of this case is a remand order requiring the district court to apply a *de novo* review standard to the Plan's decision denying her claim to the second, extended LTD benefit provided under the Plan. Pet. 10 (seeking "plenary" court proceeding); *see also Firestone*, 489 U.S. at 115. The district court, however, has already stated explicitly that if the *de novo* review standard were applied here, "the denial of benefits would survive." Pet. App. 27a n.6. As the court explained, the medical evidence submitted by petitioner in support of her claim is "inconsistent at best and contradictory at worst, with some of her doctors even disagreeing with their own diagnoses in the space of as little as two weeks." *Id.* Given that weak showing plus the views of "both independent experts, who examined the medical evidence as a whole" and concluded that she could perform light or reduced work tasks, the court concluded that petitioner had not established a valid claim to the extended LTD benefit under the terms of the Plan. *Id.* Accordingly, any time and attention invested by this Court in answering the question petitioner presents for review will be literally wasted so far as the parties in this case are concerned.

While it is of course true that, as petitioner and her *amicus* state, employee benefits issues in general have broad social and economic significance, *see* Pet. 24; AARP Br. M-1, this case itself does not turn on any controversy in employee benefits law warranting certiorari review. Petitioner's underlying benefit claim lacks support in the factual record, and the arguments in her petition lack support in the legal precedents. There is no claim, case, or conflict here worthy of review by this Court.

CONCLUSION

For the foregoing reasons, the petition should be denied.

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No. 05-1386

IN THE

Supreme Court of the United States

KATHLEEN SEMIEN,

Petitioner

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a CIGNA COMPANY, and BP LONG TERM DISABILITY (LTD) PLAN,

Respondents

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

REPLY TO BRIEF IN OPPOSITION

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REPLY TO BRIEF IN OPPOSITION

ARGUMENT

Respondents' primary assertion is that Kathleen Semien's Petition for Certiorari should be denied because the question presented, "properly understood," was "squarely answered" by this Court in *Firestone* [*Tire & Rubber Co. v. Bruch,* 489 U.S. 101 (1989)] and "followed faithfully" by the courts below. Brief Opp. at 9. Respondents are fundamentally mistaken. To be sure, *Firestone* addressed and settled the law under ERISA about the appropriate standard of review to be applied in a benefit claim brought pursuant to 29 U.S.C. §1132(a)(1)(B). But *Firestone* never limited the scope of the evidence and procedures available under the arbitrary and capricious standard as respondents maintain. [1]

Respondents' argument is also inconsistent with *Firestone's* reliance on principles of trust law. Petitioner has already established that discovery and evidentiary hearings were common in insurance disputes involving employee benefits prior to ERISA's enactment. Pet. at 15-16. Such procedures are also permitted in trust disputes even where a deferential standard of review applies. Pet. at 16. Respondents offered no response. Nor have respondents directly challenged petitioner's contention that ERISA's legislative history demonstrates Congress's intent to provide

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[1] The recent *en banc* ruling of the Ninth Circuit in *Abatie v. Alta Health & Life Ins. Co.,* 2006 U.S.App.LEXIS 20829 (9th Cir. August 15, 2006) further undermines respondents' contentions with respect to *Firestone* where the plan administrator, such as the insurer in this case, operates under a conflict of interest. In direct conflict with the Seventh Circuit's ruling here, *Abatie* relied on *Firestone* as the basis for its ruling that claimants have a right to undertake discovery without the need to make a threshold showing of bias.

benefit claimants with the same panoply of procedural and evidentiary rights that litigants receive in other civil disputes. Pet. at 12-15.

Consequently, the *Firestone* ruling was not the source of constraints that have been placed upon the scope of ERISA claim litigation. Instead, the courts of appeals have transformed ERISA's "full and fair" claim review requirement (29 U.S.C. § 1133(2)) into the equivalent of a proceeding before an administrative agency. That analogy is entirely misplaced (Pet. at 21-23), however, and was rejected both by *Herzberger v. Standard Ins. Co.*, 205 F.3d 327, 332 (7th Cir. 2005)(citing *Firestone*) and by *Brown v. Blue Cross & Blue Shield of Alabama, Inc.*, 898 F.2d 1556, 1564 n.7 (11th Cir. 1990) which explained why the use of the arbitrary and capricious standard of review familiar from administrative law should not transform private party litigation under ERISA into a quasi-administrative review proceeding:

> Because we have restated the standard as arbitrary and capricious, the temptation exists to consult precedent regarding the use of that standard to review administrative agency decisions [citations omitted]. We express caution, however, at wholesale importation of administrative agency concepts into the review of ERISA fiduciary decisions. Use of the administrative agency analogy may, ironically, give too much deference to ERISA fiduciaries. Decisions in the ERISA context involve the interpretation of contractual entitlements; they "are not discretionary in the sense, familiar from administrative law, of decisions that make policy under a broad grant of delegated powers." Van Boxel [*v.*

Journal Co. Employees Pension Trust], 836 F.2d [1048] at 1050 [(7th Cir. 1987)].

Of at least equal importance is that ERISA claims are often determined by lay persons who lack the expertise to evaluate competing medical opinions and may simply accept without question the findings made by the plan's consultants, as the Seventh Circuit noted in *Ramsey v. Hercules, Inc.*, 77 F.3d 199, 205 (7th Cir. 1996) and the Third Circuit in *Luby v. Teamsters Health, Welfare and Pension Trust Funds*, 944 F.2d 1176, 1183 (3d Cir. 1991). Nor are plan administrators "unbiased fact finders like the courts." *Id.* Likewise, ERISA claimants lack the "procedural protections that stem from the Constitution and individual statutes" provided in administrative claims. *Id.*

Thus, whether the accuracy and reliability of the evidence presented was knowledgeably considered, or instead, was ignored or overlooked, is crucial in determining whether a benefit denial is arbitrary and capricious. *See, Motor Vehicle Manufacturers Assn. v. State Farm Mutual Automobile Insur.Co.*, 463 U.S. 29 (1983).[2] Without the availability of discovery, a court has no means of evaluating whether a benefit claim was truly given a "genuine evaluation." Br. in Opp. at 17.

Finally, respondents' contention that certiorari should be denied on the ground that Semien's case would turn out the same even if she obtained relief from this Court (Brief

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[2] *Also see,* Langbein, "Trust Law as Regulatory Law: The Unum/Provident Scandal and Judicial Review of Benefit Denials under ERISA" (Northwestern University Law Review, Vol. 101, 2007)(Available at www.ssrn.com at ssrn-id917610.pdf) at 44: "Plan terms lowering the standard of review undermine the effectiveness of ERISA's requirement of fairness in internal proceedings, by making it so much harder to challenge unfairness."

Opp. at 19-20) is meritless for two reasons. First, the district court acknowledged, based on the existing record, that "there is certainly evidence within the record that would support a contrary result, one in Semien's favor..." Pet.App. 27a. The presence of such genuine issues of material fact would naturally preclude summary judgment. *See, Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The district court's denial of discovery also renders premature a conclusion that the case would turn out the same under a *de novo* standard.

Second, respondents have mischaracterized the evidentiary record. While it is true that some of Semien's physicians released her to return to work because of medical improvement in certain areas (Brief Opp. at 4), the evidence demonstrated a significant worsening in Semien's spinal and psychiatric conditions at the time benefits were withdrawn. Pet.App. 3a, 22a, 23a. To borrow a metaphor from a recent Ninth Circuit opinion involving an analogous situation in a disability benefit dispute:

> UNUM's position throughout this litigation has been that a vehicle would be suitable to drive in the months after its faulty transmission had been replaced, notwithstanding serious and credible signs pointing to the fact that the steering wheel was defective and the brakes were about to fail.

Silver v. Exec. Car Leasing Long-Term Disability Plan, 2006 U.S. App. LEXIS 20153 *20 (9th Cir. 2006). Thus, if the court were to allow discovery or conduct an evidentiary hearing to assess the "quality and quantity of the medical evidence and the opinions on both sides of the issue," (*McDonald v. Western-Southern Life Ins. Co.*, 347 F.3d 161,

172 (6th Cir. 2003)), a standard that even respondents deem "correct" (Brief Opp. at 12), a different outcome than the one reached by the lower courts is a likelihood, not a mere possibility.

Ultimately, the issue presented by the petition for certiorari is whether the Seventh Circuit correctly determined it lacked "statutory authority" to provide a "full review" of Kathleen Semien's disability benefit claim. Pet.App. 18a. Petitioner maintains the lower court applied the wrong paradigm, one that elevated expediency and efficiency over Congress' intent that ERISA claimants receive meaningful access to the federal courts. *See,* 29 U.S.C. § 1001(b). Accordingly, granting Kathleen Semien's petition is necessary to rectify the Seventh Circuit's validation of a regime that is tantamount to a rubber stamp process resulting in the unjust denial of employee benefit claims.

CONCLUSION

The petition for certiorari should be granted.

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No. 05-1386

IN THE
SUPREME COURT OF THE UNITED STATES

KATHLEEN SEMIEN,
Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a CIGNA COMPANY, and BP LONG TERM DISABILITY (LTD) PLAN,
Respondents.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF PETITIONER

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MOTION OF AARP FOR LEAVE TO FILE A BRIEF *AMICUS CURIAE*

AARP moves for leave to file the accompanying brief *amicus curiae* in support of the Petitioner Kathleen Semien, whose case is before the Court on a Petition for a Writ of Certiorari from the judgment and opinion of the United States Court of Appeals for the Seventh Circuit.

Pursuant to Supreme Court Rule 37.2(b), through counsel *amicus* sought the consents of the parties to the filing of this brief. Counsel for the Petitioner gave consent, but counsel for the Respondent withheld consent.

INTEREST OF *AMICUS CURIAE*

AARP is a nonpartisan, nonprofit organization with more than 36 million members age 50 or older, working or retired, that is dedicated to addressing the needs and interests of older Americans. Almost half of AARP's members are working. Many of the members are participants in health care plans, pension plans, short and long term disability plans and other employee benefit plans covered by the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq*. These AARP members, as well as other older Americans, depend on their ERISA employee benefit plans and the benefits the plans confer for their economic security throughout the course of their active work years and in retirement.

As of the end of U.S. government fiscal year 2005, ERISA plans covered 150 million workers and their dependents. Pension plans alone included assets of more than $4 trillion, and constituted the single largest pool of capital in the United States. U.S. Dep't of Labor, Employee Benefits Security Admin., http://www.dol.gov/ebsa.

It is important to AARP members and other employee benefit plan participants to be able to rely upon the benefits conferred by their respective plans and to be able to count on fair and equitable processing of claims for benefits under their respective benefit plans. Critical also is the means for plan

participants to have legal recourse to enforce their rights to benefits in circumstances of unjust benefit denials. These participants have a significant interest in ensuring that the instrumentalities of the courts are available to them in legal proceedings brought by them to enforce their rights. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); *cf. Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 144 (1985) (ERISA authorizes a civil action to challenge a denial of benefits). These participants also have obvious and substantial interests in ensuring that plenary court procedural processes are available to give meaning to their substantive rights to challenge disputed benefit denials. Finally, because the Department of Labor consistently has had inadequate resources to police the private system of benefit administration, plan participants have an interest in ensuring that the legal rights granted to them by ERISA legislation remain undiminished by erroneous court decisions. *See, e.g.*, PENSION & WELFARE BENEFITS ADMIN. – OPPORTUNITIES EXIST FOR IMPROVING MGMT. OF ENFORCEMENT PROGRAM, GAO-02-232, at 2-3 (GAO, March 2002); U.S. Department of Labor, PWBA TASK FORCE ON ASSISTANCE TO THE PUBLIC, 1992.

AARP thus advocates on behalf of individuals throughout the country to protect the rights of participants in private, employer-sponsored employee benefit plans covered by ERISA, 29 U.S.C. § 1001 *et seq.* As part of the Association's advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP has participated as *amicus curiae*, in numerous cases involving fiduciary duties and remedies under ERISA. *See, e.g., Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 204 (2002); *Harris Trust & Sav. Bank v. Salomon Smith Barney Inc.*, 530 U.S. 238 (2000); *Mertens v. Hewitt Assocs.*, 508 U.S. 248 (1993); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); *Harley v. 3M*, 284 F.3d 901, (8th Cir.), *cert. denied*, 537 U.S. 1106 (2003).

The resolution of the issue before the Court will have a direct and vital bearing on the ability of employee benefit plan participants to exercise their rights to challenge benefit denials by employer-sponsored plans and thereby to protect their own

economic well-being and that of their families. In light of the significance of the issue presented by this case, *amicus curiae* respectfully submits this brief to facilitate a full consideration by the Court of the Petition.

REASONS FOR GRANTING THE MOTION

In addition to the conflict between the Seventh Circuit and the other circuits on the question presented by Petitioner, a Writ of Certiorari is appropriate because the Seventh Circuit decision seriously undermines the rights of all participants in employer-sponsored benefit plans of all types to mount a meaningful challenge to benefit denials by insurance carriers who act both as benefit plan administrator and funding source. If the Court does not grant the Petition for a Writ of Certiorari, the Seventh Circuit's holding that participants who challenge the benefit eligibility determination of an arguably conflicted plan fiduciary have limited rights to discovery. Not only will it constitute a radical departure from the language and intent of the ERISA statute, it will also undermine the carefully integrated civil enforcement provisions of the Act and create a virtual void in the statute's remedial structure insofar as individual participants are concerned. With this critical curtailment of ERISA's express remedies, the financial security of millions of participants in employer-sponsored plans is thrown into jeopardy due to their inability to police and protect their rights in their plan benefits.

The Seventh Circuit's decision is far-reaching in its impact on all participants of private employer-sponsored benefit plans not only as to disability insurance such as is involved in Ms. Semien's claim, but also as to health insurance, life insurance, severance benefits, pension benefits, etc. This case presents an opportunity to clarify and reinforce the role and powers of the federal courts under ERISA when participants challenge benefit denials by conflicted plan administrators.

June 2, 2006

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ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) .. *passim*

MISCELLANEOUS

Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U.L.REV. 1083, (2004) (2d ed. Rev. 1980) 10

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No. 05-1386

IN THE

Supreme Court of the United States

KATHLEEN SEMIEN,

Petitioner,

v.

LIFE INSURANCE COMPANY OF NORTH AMERICA, a CIGNA COMPANY, and BP LONG TERM DISABILITY (LTD) PLAN,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SEVENTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICUS CURIAE* AND BRIEF *AMICUS CURIAE* OF AARP IN SUPPORT OF PETITIONER[1/]

INTEREST OF *AMICUS CURIAE*[2/]

[1/] No counsel for any party authored any portion of this brief. No person other than *amicus curiae*, its members, or its counsel made a monetary contribution to the preparation and submission of this brief.

[2/] *Amicus Curiae* has described its interest in the accompanying Motion of AARP for Leave to File a Brief *Amicus Curiae* which precedes this Brief, and does not repeat the same in this section of the Brief.

SUMMARY OF ARGUMENT

Firestone Tire & Rubber Co. v. Bruch has led a number of courts to limit the scope of review in ERISA challenges to benefit denials by adminisrator/insurers under ERISA § 502(a)(1)(B). In cases where the court reviews the eligibility determination of an insurance company under a deferential standard, plenary rights to exercise discovery to investigate the insurer's potential conflicts of interest and procedures for claim processing are critical to ERISA's civil enforcement provisions.

Absent claimants having plenary discovery rights in ERISA benefit litigation, the potential for abuse and overreaching by insurers is substantial. It is the office of the federal courts to preside vigilantly over the rights of ERISA plan participants and beneficiaries.

ARGUMENT

I. THE COURT'S DECISION IN *FIRESTONE TIRE & RUBBER CO. v. BRUCH* HAS SPAWNED A HOST OF DISTURBING HOLDINGS OVER THE ROLE OF THE FEDERAL COURTS IN CHALLENGES UNDER ERISA § 502(a)(1)(B).

In *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989), the Court unambiguously held that *de novo* is the presumptive standard for judicial review of ERISA benefit denials. That approach, which prescribes no deference to the prior determination of an ERISA plan administrator and the fact that the decision maker as to the employee's eligibility for benefits may be the very insurance company that will be obligated to pay the benefits, is of legal consequence only in that it sets the stage for civil enforcement proceedings initiated by the plan participant to challenge the company's denial under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 (a)(1)(B). Under *de novo* review, ultimately the court's own analysis of the record will prevail. Insofar as the judicial handling of the matter is concerned, it can be said that the holding of *Firestone* is the

presumption that the parties contend on a level playing field. *Firestone* did not stop there, however.

In the course of its *Firestone* analysis, the Court also commented in passing that where a plan gives the administrator or fiduciary discretionary authority to determine eligibility for benefits or to interpret the terms of the plan, then the deferential "arbitrary and capricious" standard is used. That statement in *Firestone* was qualified by the caveat that "if a benefit plan gives discretion to an administrator or fiduciary who is operating under a conflict of interest, that conflict must be weighed as a 'facto[r] in determining whether there is an abuse of discretion.'" *Id.* (quoting Restatement (Second) of Trusts §187, cmt. d (1959)) (alteration in original). This *Firestone* tangent has become the point of departure for many federal trial and lower appellate courts, post-*Firestone*, to continue to entertain the deferential, "arbitrary and capricious" or "abuse of discretion" standard of review in proceedings under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132 (a)(1)(B), notwithstanding respectable and well articulated skepticism about the appropriateness of doing so. *But see Varity Corp. v. Howe*, 516 U.S. 489, 497 (recognizing that "trust law does not tell the entire story," the majority referenced ERISA's legislative history to caution that despite the trust-like fiduciary standards ERISA parallels, it was Congress' intent that courts interpret ERISA's fiduciary standards "bearing in mind the special nature and purpose of employee benefit plans"). The deferential standard had prevailed in challenges to benefit denials prior to the passage of ERISA, and courts were reluctant to depart from it. The pivotal point of controversy in *Firestone* is the Court's mechanical resort to trust law as the presumed source from which a standard may be derived for the review of claims under § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), and the persistent application by the lower courts of the deferential standard on the authority of *Firestone*, particularly in the context of employee benefit plans that are funded by insurance.[3/]

[3/] Although *Firestone* has generally been recognized as the controlling decision in determining the standard of review in all ERISA cases, as the Eleventh Circuit and others have observed, whether the trust law principles

As a review of the ERISA decisions on statutory challenges to benefit denials will demonstrate, a substantial number of the reported cases involve an employee's filing of a civil action seeking to enforce a claim to a plan benefit in circumstances in which the pre-litigation determination of ineligibility was made by an insurance company which acted both as plan administrator and insurer, i.e., funding source for the benefit. As can be seen from the discussion that follows, the Court's reference in *Firestone* to trust law principles was and remains ill-suited to the task of resolving disputes under ERISA § 502(a)(1)(B) between benefit claimants and insurance companies who act in that dual role.[4/] The difficulty arises on account of the practice that has evolved in the courts in the name of deference for the court to act as a reviewing body, rather than as a tribunal vested with the power and

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relied upon in *Firestone*, which involved an employer-funded plan, have any application in the context of an insurance-funded plan where the insurer doubles as the plan administrator, is open to serious question. *See Brown v. Blue Cross & Blue Shield*, 898 F. 2d 1556, 1563 n.6 (11th Cir. 1990); ("Strong language endorses the right of the parties to contract for a standard of review, but that right is premised on assumptions regarding trust law that do not apply to insurance policy plans.") In *Firestone*, the Court withheld opinion on this issue. 489 U.S. 101, 115 ("Because we do not rest our decision on the concern for impartiality that guided the Court of Appeals, we need not distinguish between types of plans or focus on the motivations of plan administrators and fiduciaries.") (internal citation omitted).

[4/] *Darland v. Fortis Benefits Ins. Co.*, 317 F.3d 516, 527-28 (6th Cir. 2003) (noting that apparent conflict of interest should have been taken into account); *Bynum v. CIGNA Healthcare*, 287 F.3d 305, 311-12 (4th Cir. 2002) (holding insurer has substantial conflict of interest in defining policy terms); *Buce v. Allianz Life Ins. Co.*, 247 F.3d 1133, 1141 (11th Cir. 2001) (holding insurer's dual role posed conflict of interest), *cert. denied*, 534 U.S. 1065 (2001); *Schatz v. Mutual of Omaha Ins. Co.*, 220 F.3d 944, 948-49 (8th Cir. 2000) (dual role raises rebuttable presumption of conflict); *Pitman v. Blue Cross & Blue Shield of Okla.*, 217 F.3d 1291, 1296 (10th Cir. 2000) (observing that when plan administrator and insurer are identical conflict may be manifest); *Pinto v. Reliance Standard Life Ins. Co.*, 214 F.3d 377, 378 (3rd Cir. 2000) (holding that where insurer fulfills dual role of plan administrator and plan funding source it generally acts under conflict).

responsibility to exercise judicial traits such as sound, independent, critical analysis on the record before the court. Indeed, in a vast number of cases involving a grant to the administrator/insurer of discretion to determine the benefit claimant's eligibility for the claimed benefit, the case decisions reveal "**a uniformly lenient regime of reviewing benefit determinations**," *Rush Prudential HMO, Inc. v. Moran*, 536 U.S. 355, 385 2002), contrary to ERISA's prescribed civil enforcement remedies.

If anything may be gleaned from the ERISA statute, its legislative history, and from the Court's ERISA decisions, surely it is beyond dispute that Congress never intended the courts to be a rubber stamp for the benefit eligibility determinations of insurers. Moreover, the Court has recognized the problem with a deferential standard of review in the case of administrator/insurers in the ERISA claims context. *Id.* at 384. By limiting the applicability of the Rules of Civil Procedure to benefit denial challenges under ERISA, the Seventh Circuit's *Semien* holding turns a deaf ear to the Court's acknowledgment of the problem.

Nor is the reach of the Seventh Circuit's holding limited to claimants for disability plan benefits. The principle enunciated by that court, *i.e.*, that the Article III powers of district courts in claims brought under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B) are limited to reviewing the determination of a non-tribunal that has a financial interest in the outcome, has significant and far-reaching implications well beyond the disability benefit claim context. Under the Seventh Circuit's view limiting ERISA claimants' recourse to effectively challenge benefit denials, health insurers and life insurers, too, when they also act as plan administrators, may with virtual impunity decide claims based upon their self-interest, driven primarily by the profit motive, rather than by their statutory obligations to plan participants and beneficiaries to act solely in the best interests of plan participants. Indeed, the Court has noted the potential for conflict when an HMO makes decisions about appropriate treatment. *Pegram v. Herdrich*, 530 U.S. 211, 219-20 (2000). No less at risk of being denied their rights to vindicate serious breaches of fiduciary

duty on account of the *Semien* holding are participants in ESOP and other defined contribution plans that handle substantial sums of employees' own funds. In derogation of the congressional charge in ERISA that courts are to safeguard the reasonable expectations of participants and beneficiaries in their employee benefit plans, by denying traditional discovery as a matter of right the Seventh Circuit withholds from ERISA litigants the procedural and substantive processes routinely available in civil actions.

II. ERISA'S GRANT TO PLAN PARTICIPANTS OF CIVIL ENFORCEMENT RIGHTS OF ACTION IS A FUNDAMENTAL ASPECT OF THE STATUTE'S SCHEME FOR PROTECTION OF EMPLOYEE BENEFITS.

A. Because ERISA § 502(a)(1)(B) Directs That A Participant May Bring a Civil Action to Recover Benefits Due or to Enforce Rights Under the Terms of a Plan, Participants Must Have Plenary Access to Discovery Tools.

Section 502(a)(1)(B) states that "[a] civil action may be brought by a participant or beneficiary to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;" 29 U.S.C. § 1132(a)(1)(B). This provision is the manifestation of congressional action "to promote the interests of employees and their beneficiaries in employee benefit plans." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). The Seventh Circuit's limitation of plan participants' rights to pursue ERISA enforcement actions by restricting their use of the discovery provisions of the Federal Rules of Civil Procedure to investigate the claims handling process in litigation between plan participants and administrator/insurers flies in the face of the congressional purpose of ERISA's civil enforcement provisions. Moreover, it makes a mockery of the Court's admonition in *Firestone* "that conflict must be weighed as a facto[r] in determining whether there is an abuse of discretion" in cases where a deferential

standard of review is employed. 489 U.S. at 115. The Seventh Circuit's holding makes it impossible for a litigant through discovery to develop the record on the administrator/insurer's conflict of interest and the critical details of the insurance company's management of the claim, thus insulating the insurer's eligibility determination from scrutiny and in equal measure robbing the claimant of the essence of his challenge under the ERISA statute and *Firestone*. The holding thus elevates to sacrosanct the self-serving benefit eligibility determinations of insurers and renders hollow ERISA's protections for plan participants. Neither Congress nor the Court has seen fit to so subordinate ERISA's mandate.

B. Case Law Demonstrates That Subjecting Insurers' Eligibility Determinations To Careful Scrutiny Promotes More Equitable Outcomes In ERISA Benefit Litigations.

Numerous are the published decisions that reveal overly aggressive claims denial practices by administrator/insurers in the ERISA benefit claims arena. One company has established notoriety in no fewer than four circuit courts of appeals and several district courts for its claim review procedures, highlighting such practices as "selective review of the administrative record;"[5] "lack of objectivity and abuse of discretion;"[6] reliance upon "ambiguous test results;"[7] irrational claims procedures;[8] conduct "border[ing] on outright fraud;"[9]. Chief Judge Young of the District Court of Massachusetts

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[5] *Moon v. Unum Provident Corp.*, 405 F.3d 373, 381 (6th Cir. 2005).

[6] *Lain v. Unum Life Ins. Co.*, 279 F.3d 337, 347 (5th Cir. 2002).

[7] *Stup v. Unum Life Ins. Co.*, 390 F.3d 301, 310 (4th Cir. 2004).

[8] *Dandurand v. Unum Life Ins. Co.*, 284 F.3d 331, 338 (1st Cir. 2002).

[9] *Watson v. Unum/Provident Corp.*, 185 F.Supp. 2d 579, 585 (D.Md. 2002).

observed that based on some twenty cases he had reviewed involving the same company there was "revealed a disturbing pattern of erroneous and arbitrary benefit denials, bad faith contract misinterpretations, and other unscrupulous tactics" that constituted conduct "entirely inconsistent with the company's public responsibilities and with its obligations under its [ERISA] Policy."[10/]

The same company's claims processing conduct attracted the attention of several state insurance regulators, who, acting in concert and individually, secured an agreement for the company to pay more than $20 million in fines and to reopen several years of adverse claims determinations.[11/] The patterns and practices discussed in the cases came to light in the course of proceedings brought by benefit claimants under ERISA § 502(a)(1)(B). Absent the litigants' rights to make necessary and relevant discovery under the Federal Rules of Civil Procedure, the company in question might well have been able to persist in its questionable conduct.

By restricting § 502(a)(1)(B) claimants' access to the discovery process in the district court, the Seventh Circuit's holding forecloses a participant's opportunity to develop the actuality and extent of a conflict of interest on the part of an ERISA administrator/insurer and the nature and extent of unlawful and objectionable claims processing procedures. Absent the opportunity to initiate and pursue discovery in the trial court on those critical factual issues, an ERISA litigant is effectively stripped of the right to enforce his/her benefit entitlement under the statute. The Circuit's holding promotes overreaching by administrator/insurers, and thus it is fatally

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[10/] *Radford Trust v. First Unum Life Ins. Co.*, 321 F.Supp. 2d 226, 247 n.20 (D. Mass. 2004).

[11/] *See Report of the Targeted Multistate Market Conduct Examination for Maine Bureau of Insurance, Mass. Div. Of Ins., Tenn. Dep't of Commerce and Ins. & Forty-Nine Participating Jurisdictions*, available at http://www.maine.gov/pfr/ins/Unum_Multistate_ExamReport.htm (Feb. 29, 2004).

flawed. Under the review regime envisioned by that court, the federal trial courts become mere shills for unscrupulous insurers to practice fraud upon highly vulnerable plan participants.

C. ERISA's Civil Enforcement Provisions Prescribe No Limitation on the Application of the Rules of Civil Procedure to the Rights of Participants to Prosecute Civil Actions to Enforce Plan Rights.

The Seventh Circuit's reading of limitations on discovery into ERISA's civil enforcement provisions is without precedent or statutory warrant. When interpreting ERISA's carefully integrated civil enforcement provisions under § 502(a), the Court repeatedly has looked at the plain language of ERISA, the evident care with which the civil enforcement provisions were crafted, the structure of the statue, and the policies underlying ERISA. Without exception, the Court has emphasized that the precise language of the statute must be followed. As the Court has been unwilling to read into ERISA implied claims or remedies, so has it also been unwilling to read limiting language into the statute. *See Great-West Life & Annuity Ins. Co. v. Knudson*, 534 U.S. 209, 209; *Harris Trust & Sav. Bank v. Solomon Smith Barney, Inc.*, 530 U.S. 237, 247; *Varity Corp.*, 516 U.S. at 512; *Mertens v. Hewitt Assoc.*, 508 U.S. 248, 261-62 ; *Mass. Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 141-42. In contrast, the Seventh Circuit did exactly what the Court has been unwilling to do. The Seventh Circuit has done nothing less than to graft onto ERISA a limitation of the discovery provisions of the Federal Rules of Civil Procedure. On this ground alone, the Petition for a Writ of Certiorari should be granted.

D. The Seventh Circuit's Relegation of the Courts to Mere Review of ERISA Benefit Denial Decisions is an Abdication of the Role Assigned to the Courts by Congress under ERISA To Preside Over § 502(a)(1)(B) Benefit Claims.

In curtailing ERISA litigants' routine access to discovery procedures to enable a full inquiry into the nature and extent of an administrator/insurer's conflict of interest and details concerning insurers' claims processing practices, the Seventh Circuit disregards ERISA's command pertaining to fiduciary loyalty, which requires plan fiduciaries to act "solely in the interest of the participants and beneficiaries and . . . for the exclusive purpose of . . . providing benefits to participants and their beneficiaries . . ." ERISA § 29 U.S.C. 404(a)(1)(A), § 1104 (a)(1)(A).[12/]

Inasmuch as it is the avowed purpose of ERISA "'to promote the interests of employees and their beneficiaries in employee benefit plans' . . . and 'to protect contractually defined benefits, '" ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D) should be read to trump over plan terms conferring discretion that abridge ERISA's duty of loyalty in the context of the determination of eligibility for benefits. Thus, courts that confer presumptive rubber-stamp approval to benefit eligibility denials by self-serving administrator/insurers without permitting litigants the opportunity to conduct essential discovery give the insurers a free pass to shirk their ERISA mandated fiduciary duties. *See Wilkins v. Baptist Healthcare*

[12/] The importation from trust law of the duty of loyalty to ERISA in the context of applying the duty to insurers who double as plan administrators and also serve as funding source for plan benefits points up the difficulty inherent in *Firestone's* derivation of the standard of review from trust law. 29 U.S.C. 1002(21)(A)(2005) (ERISA defines "fiduciary" broadly as a person who exercises any discretionary authority with respect to management of a plan even if that person lacks the granting of discretion envisioned under trust law to justify an arbitrary and capricious deferential standard of review in the context of ERISA benefit denials); *see generally* Kathryn J. Kennedy, *Judicial Standard of Review in ERISA Benefit Claim Cases*, 50 AM. U.L.REV. 1083, 1105-6 (citing George Gleason Bogert & George Taylor Bogert, *The Law of Trusts and Trustees* 558, 560 (2d ed. Rev. 1980) (observing that trust law makes a distinction between a trustee's discretionary and non-discretionary authority in that if a trustee failed to carry out his duties, courts could apply de novo review in assessing the trustee's failure to perform).

Sys., Inc., 150 F.3d 609, 619 (6th Cir. 1998) (Gilman, J., concurring) (noting that a district court may allow discovery and hear evidence outside the administrative record if that evidence is offered in support of a procedural challenge to the administrator's decision, such as an alleged bias, in an ERISA benefit denial case). Inasmuch as the Seventh Circuit's *Semien* decision validates such passive judicial handling of ERISA claims under § 502(a)(1)(B), it facilitates an abdication by the courts of their congressionally assigned role to actively preside over ERISA benefit claims. The Court should grant the Petition for a Writ of Certiorari to curb that practice in the lower courts.

CONCLUSION

For the foregoing reasons, *Amicus Curiae* respectfully urges the Court to grant the Petition for a Writ of Certiorari.

June 2, 2006

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